1993

South Davis Community Hospital v. Utah Department of Health : Brief of Respondent

Utah Court of Appeals

George K. Fadel; Attorney for Petitioner.
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930013

IN THE COURT OF APPEALS OF THE STATE OF UTAH

SOUTH DAVIS COMMUNITY HOSPITAL, INC./ ROMERO,	:	
Petitioner,	:	Case No. 930013-CA
v.	:	Priority No. 14
UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING,	:	
Respondent.	:	

BRIEF OF RESPONDENT

- - - - - - - - -

PETITION FOR REVIEW OF A FINAL AGENCY ACTION
OF THE UTAH DIVISION OF HEALTH CARE FINANCING
DEPARTMENT OF HEALTH,
ROD BETIT, INTERIM EXECUTIVE DIRECTOR

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JURISDICTION

Jurisdiction is proper pursuant to Utah Code Ann. § 63-46b-16 (1989); Utah Code Ann. § 78-2a-3(2)(a) (Supp. 1992).

STATUTES INVOLVED

The following statutes and rules are relevant to the determination of this case: 42 U.S.C. §§ 1396a(A)(30), 1396a(a)(44)(A), 1396b(g)(6)(A) (1992); 42 C.F.R. §§ 456.60, 456.260 (1992); Utah Admin. Code R455-9-1 (1989) and Utah Admin. Code R455-9-1, R455-9-6, R455-9-19, R455-9-27, R455-9-28 (1990). The full texts of these are set forth in Addendum A to this brief.

ISSUE PRESENTED

1. Did the Division of Health Care Financing ("DHCF") reasonably deny South Davis Community Hospital ("South Davis") Medicaid reimbursement for treatment provided to Catherine Romero for the period of August 1, 1989 through October 31, 1989?

STANDARD OF REVIEW

The sole issue properly before this Court is whether DHCF reasonably determined that South Davis failed to have a physician's certification and recertification of Ms. Romero's need for care as required by federal Medicaid law. DHCF's application of Medicaid law must be affirmed if it is within the bounds of reasonableness. King v. Industrial Comm'n of Utah, 209 Utah Adv. Rep. 33, 35 (Utah App. 1993); Morton Int'l, Inc. v. Auditing Division, 814 P.2d 581, 586-87, 589, 592 (Utah 1991); Cross v. Board of Review, 824 P.2d 1202, 1204 (Utah App. 1992); see Utah Code Ann. § 63-46b-16(4)(h)(i) (1989).

STATEMENT OF THE CASE

A. Nature of the Case. This is a case to determine whether DHCF reasonably denied South Davis's application for Medicaid reimbursement for care given Catherine Romero for the period of August 1, 1989 through October 31, 1989.

B. Course of Proceedings. Petitioner, South Davis, is a licensed Specialty Hospital and Medicaid provider in the State of Utah which offers patients care at both the acute and skilled nursing care levels. Record (hereafter "R.") at 18.[1] Beginning in May 1983, and continuing to the present time, South Davis has provided medical care to Catherine Romero for her chronic, severe degenerative neuromuscular disease. R. at 4, 18, 44. Although Ms. Romero has at all times been Medicaid eligible,

[1] Neither party requested a transcript of the hearing since Catherine Romero's entire medical file is included as part of the record before this Court.

this case is brought by South Davis to challenge a reimbursement denial and not by Ms. Romero as an on-going Medicaid recipient. R. at 64.

Beginning with her admission in May 1983 and until July 31, 1989, Ms. Romero's care at South Davis was paid for by a private health insurance company. R. at 18. When her private insurance coverage terminated, Ms. Romero applied for Medicaid coverage and became eligible on August 1, 1989. Id. On December 27, 1989, South Davis requested DHCF to reimburse the costs of care given to Ms. Romero for the period of August 1, 1989 to October 31, 1989. R. at 18. Specifically, South Davis received reimbursement for the first seven days of Ms. Romero's treatment based upon DHCF's relevant Diagnostic Related Group ("DRG"), and was denied payment for the remaining 84 "outlier" days which are the subject of this appeal. R. at 18, 64.

In a letter sent to South Davis on May 7, 1990, DHCF explained that South Davis's application for Medicaid reimbursement for these "outlier" days was denied on the following grounds: (1) neither the severity of the illness nor the intensity of the service given to Catherine Romero met criteria necessary to justify reimbursement at an acute care level of service; and (2) there was no physician's certification or recertification of the need for acute care services at South Davis contained in Ms. Romero's medical record during the period in dispute. R. at 18 & 64.

On July 30, 1990, pursuant to South Davis's request, a

formal administrative hearing was held before Cornelius W. Hyzer, Hearing Officer at the Cannon Health Building in Salt Lake City. R. at 17. Gordon W. Bennett appeared on behalf of petitioner and was represented by George K. Fadel. Id. DHCF was represented by J. Stephen Mikita. Id. At the conclusion of this hearing, the Hearing Officer left the record open to provide South Davis with an opportunity to submit additional evidence regarding the level of care given to Ms. Romero. Id. On December 8, 1992, the Hearing Officer recommended that the agency's decision denying South Davis's request for reimbursement be upheld. R. at 19.

On December 23, 1992, Interim Executive Director, Rod Betit, affirmed the Hearing Officer's Recommended Decision denying South Davis's request for Medicaid reimbursement. R. at 11-16. South Davis filed a Petition for Review of Final Agency Action with this Court on January 12, 1993. R. at 3-7, 10.

STATEMENT OF THE FACTS

On May 11, 1983, Catherine Romero was admitted to South Davis Community Hospital for treatment of a progressive degenerative neuromuscular disease. R. at 4, 18, 57. With the exception of three days in September 1987, Ms. Romero has remained a patient at the facility since her initial admission nearly ten years ago.[2] R. at 4, 18, 44, 55. Until the period in dispute, Catherine Romero's medical costs were reimbursed

[2] On September 7, 1987, Ms. Romero suffered a respiratory arrest at which time she was transferred for treatment to Lakeview Hospital. Once she became stabilized, Catherine was readmitted to South Davis on September 10, 1987. R. at 55.

through private health insurance coverage. R. at 18, 55. When the limits of this policy were reached, Ms. Romero's family applied for Medicaid coverage, which became effective on August 1, 1989. Id. DHCF declined to reimburse South Davis for Ms. Romero's care from August 1, 1989 through October 31, 1989 due to South Davis's failure to comply with state and federal Medicaid regulations. Id. Following this disputed period, South Davis, beginning on November 1, 1989 and continuing to the present, has correctly applied for and received Medicaid reimbursement for treatment given to Ms. Romero at a skilled, not acute, level of care. R. at 19, 55.

On December 27, 1989, South Davis applied for Medicaid reimbursement at an acute care level for the three months which are the subject of this appeal -- August 1, 1989 to October 31, 1989. R. at 18. On May 7, 1990, DHCF denied this request for reimbursement, stating that (1) Ms. Romero's medical condition did not require nor did Ms. Romero receive care at an acute level; and (2) Ms. Romero's medical records lacked the requisite physician's certification or recertification pursuant to state and federal law to justify reimbursement at any rate. R. at 19, 55, 64. The issue presented at the Formal Hearing held on July 30, 1990 was whether the agency correctly denied South Davis's request for Medicaid reimbursement. R. at 17.

Following the Hearing Officer's determination that Ms. Romero did not receive or require an acute level of care from August 1, through October 31, 1989 and that the lack of physician

certification for the applicable period precluded Medicaid from authorizing payment for any services provided to Ms. Romero, the Interim Executive Director, Utah Department of Health, Mr. Rod Betit, affirmed this decision. R. at 12.

In his Reasons for Disposition, Mr. Betit explained that, pursuant to 42 U.S.C. § 1396a(30)(A) (1992), a participating State must have necessary procedures relating to the utilization of long-term care to "safeguard against unnecessary utilization of such care and to assure that payments are consistent with efficiency, economy and quality of care." R. at 12. Further, Mr. Betit stated that, pursuant to this rule, a State will be penalized for failing to implement and enforce such a program of utilization review and thus would receive a "reduction in the amount of Federal Medicaid funds paid to [the] State for long-stay patient services." See 42 C.F.R. § 456.1(b) (1990). Id.

Further, Mr. Betit stated, in part, these regulations require that "no applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care can be met a less intense level." Utah Admin. Code R455-9-1 (1989) (currently enumerated R. 414-9). R. at 13. Additionally, where the State of Utah has been granted a Superior Systems Waiver, i.e., prepayment [DRG] outlier review, Mr. Betit continued that South Davis must present DHCF with sufficient documentation regarding Ms. Romero's treatment so that it may be "reviewed for appropriateness of continued stay, correctness of diagnoses . . . ." Id. Pursuant to this review of South Davis's

request for "outlier" days, Mr. Betit concluded that the intensity of service and severity of illness criteria did not justify keeping Ms. Romero in an acute care setting. R. at 14.

Pursuant to the testimony of Dr. John C. Hylen, a Department of Health physician and consultant of the Utah Utilization Review Committee, regarding whether Ms. Romero met the criteria for acute care, Mr. Betit stated that despite Ms. Romero's ventilator dependency, her condition was stable and did not warrant an acute level of care. Id. Mr. Betit concluded that Ms. Romero's health care needs could be, and in fact were, accommodated at a lower level of care. Id.

Additionally, Mr. Betit concluded that Ms. Romero's medical files lacked both a physician's certification and recertification as required by state and federal law. R. at 15. Pursuant to 42 U.S.C. § 1396a(44)(A):

> [I]n each case for which payment for inpatient hospital services . . . is made under the State plan --
>
> a physician . . . **certifies at the time of admission** or if later, [at] the time the individual applies for medical assistance under the State plan . . . and . . . **recertifies**, where such services are furnished over a period of time, . . . **that such services are or were required to be given on an inpatient basis because the individual needs or needed such services** . . . .

(Emphasis in original). R. at 15. Thus, where South Davis failed to comply with this federal Medicaid requirement, Mr. Betit reasonably concluded that DHCF correctly denied its request for Medicaid reimbursement for the period of August 1, 1989 through October 31, 1989. Id.

SUMMARY OF THE ARGUMENT

DHCF reasonably denied South Davis's application for Medicaid reimbursement for care given Ms. Catherine Romero during the period of August 1, 1989 through October 31, 1989. DHCF's denial of reimbursement was based on (1) the lack of physician's certification or recertification of acute care services during this period and (2) the fact that Ms. Romero's medical condition did not require or receive acute care medical services.

To participate in the Medicaid program, participating states must implement utilization review procedures to safeguard against unnecessary utilization of care and assure that reimbursements are consistent with efficiency and economy. As part of a utilization review program, providers must demonstrate that a physician certified at the time of a patient's admission into a hospital the need for a particular level of care. South Davis failed to comply with this federal requirement.

Finally, DHCF correctly concluded that Catherine Romero's medical condition was treatable and thus reimbursable at a less intense, equally effective level of care.

ARGUMENT

Introduction

South Davis contends that DHCF incorrectly and arbitrarily denied Medicaid reimbursement for acute care services provided to Catherine Romero for the three-month period -- August 1, 1989 through October 31, 1989. South Davis insists at the very least, that it should be reimbursed for the reasonable cost of service

rendered pursuant to a Medicare, not Medicaid, regulation. Furthermore, South Davis believes that a physician's certification and recertification of Ms. Romero's level of care during this time should be inferred from physician's orders and nurses' progress notes found in Ms. Romero's medical file. Finally, South Davis argues that DHCF has the discretion to reimburse the hospital at a skilled nursing care level despite the lack of physician's certification.

However, a review of the relevant federal and state regulations regarding physician's certification and recertification required for Medicaid reimbursement supports DHCF's determination that the lack of physician's certification or recertification for the period in question prevented the agency from legally authorizing payment for these services, regardless of the level of care rendered to Ms. Romero from August 1 through October 31, 1989. DHCF's decision is entirely consistent with Congress's overriding concern that the Medicaid program be administered and operated in an efficient and economical manner.

Overview of Utah's Medicaid and Utilization Review Programs

Medicaid was established by Congress in 1965 as Title XIX of the Social Security Act[3] "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." Harris v. McRae,

[3] Public Law No. 89-97, as amended, 79 Stat. 334 (codified at 42 U.S.C. §§ 1396 et seq. (1992)).

448 U.S. 267, 301 (1980). It is a program designed "to make medical services for the needy more generally available," S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1 at 2014 (1965). Medicaid reimburses participating States a percentage of the cost of medical care provided to these types of eligible individuals and families. See Atkins v. Rivera, 477 U.S. 154, 156-57 (1986). The federal government reimburses Utah at a 75% rate, and the State pays the remaining 25% of the cost of the Medicaid program.

In order to obtain reimbursement, a participating state must develop a plan that complies with the Medicaid statute and federal implementing regulations, see 42 U.S.C. § 1396; Atkins, 477 U.S. at 157, and it must select a single agency to administer the plan. 42 U.S.C. § 1396(a)(5) (1992). The state plan must be approved by the Department of Health and Human Services, the federal agency that oversees implementation of the Medicaid program. 42 U.S.C. § 1396 (1992); Schweiker v. Gray Panthers, 453 U.S. 34, 37 (1981).

Utah chose to participate in Medicaid with the adoption of the Medical Assistance Act in 1981. See Utah Code Ann. §§ 26-18-1 to -11 (1989 and Supp. 1993). DHCF is the designated Utah agency responsible for administering the Medicaid program in accordance with federal and state law requirements. Utah Code Ann. § 26-18-3(1) (Supp. 1993); Utah Code Ann. § 26-18-2.1 (1989). DHCF is responsible for "implementing, organizing, and maintaining the Medicaid program." Utah Code Ann. § 26-18-2.1 (1989). DHCF's responsibilities are set forth in Utah Code Ann.

§ 26-18-2.3(1), which provides, in pertinent part:

> [T]he division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay

(emphasis added). In addition, Utah's Medicaid statute provides, "The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations." Utah Code Ann. § 26-18-3(2) (Supp. 1993).

To this end, a State "must provide such methods and have procedures relating to the utilization of, and payment for, care and services available under the [State Medicaid] plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care . . . ." 42 U.S.C. § 1396a(30)(A) (1992). States that fail to show that they have programs that protect against the unnecessary and costly utilization of long-term inpatient services will be penalized by the federal government. Specifically, 42 C.F.R. § 456.1 (1992) states:

> (2) *Penalty for failure to have an effective program to control the utilization of institutional services.* Section 1903(g)(1) [of the Social Security Act] provides for a reduction in the amount of Federal Medicaid [matching] funds paid to a State for long-stay inpatient services . . . This penalty provision applies to inpatient services in hospitals . . . [and] skilled nursing facilities.

(Emphasis in original).

Pursuant to this provision, the federal government may deny

essential matching funds to states unless (1) the institution (i.e., a skilled nursing facility) has in effect a utilization review program which meets federal Medicaid requirements; or (2) the Medicaid agency has been granted a waiver from the Department of Health and Human Services based on the State's implementation of a superior program of utilization review. Accordingly, the State of Utah opting for a superior program of utilization review, was granted such a waiver, known as a "Superior Systems Waiver." Pursuant to this waiver, the Utah Medicaid Program and Utah Medicaid providers must adhere to procedures and requirements established by DHCF in order to receive reimbursement.

Specifically, Medicaid providers in Utah that offer either long-term care nursing services, acute services, or both, must meet certain criteria to qualify for payment. In pertinent part, Utah Admin. Code R455-9-1 (1990) states the purpose of Utah's Preadmission and Continued Stay Review program is "(3) to ensure that certification for placement and reimbursement of nursing care facility services or for a State institution for acute care is given prior to placement." See Addendum D, Respondent's Exhibit No. 8, Utah Department of Health, DHCF, Policy and Procedure Manual, January 3, 1989, E-48.[4] Two primary requirements under this program include: (1) A "physician will

[4] While not yet printed in the Utah Administrative Code, this rulemaking, policy and procedure manual -- effective January 3, 1989 -- was the policy in effect for purposes of the Interim Executive Director's decision, not solely Utah Admin. Code R455-9-1 (1989), which has the same effective date.

certify the need for inpatient services at the time the determination is made of the patient's/resident's level of care . . The physician . . . will recertify the . . . continued need for inpatient nursing facility care/services . . . every 60 days after certification." Addendum D at E-67; see Utah Admin. Code R455-9-19(A) (1990); and (2) "No applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care." Addendum D at E-93; see Utah Admin. Code R455-9-28(E) (1990).

These requirements are designed to safeguard against unnecessary utilization of care and services conducted by Medicaid providers. Further, under Utah's "Prepayment [DRG] Outlier Review" plan, the State will not grant Medicaid reimbursement for the costs of medical treatment rendered, absent a showing in the medical record of the appropriateness of those services, which includes, the appropriateness of the patient's level of care, of the continued stay and the correctness of the physician's diagnoses. Director's Exhibit No. 1, R. at 13-14, 24-40; Utah State Department of Health, Hospital Utilization Review Superior Systems Waiver. Under these criteria, a facility will not be reimbursed unless the intensity of service provided to the patient or the severity of the patient's illness justify reimbursement at the requested level of care. See Respondent's Exhibit No. 6, "Override Option I, Appropriateness Evaluation Protocol." Consequently, it is against these standards and

policies that DHCF must evaluate requests for reimbursement by providers, such as South Davis.

POINT I

DHCF REASONABLY DENIED SOUTH DAVIS REIMBURSEMENT FOR 84 OUTLIER DAYS BASED UPON SOUTH DAVIS'S FAILURE TO COMPLY WITH RELEVANT STATE AND FEDERAL REGULATIONS.

South Davis insists that, because DHCF does not dispute the quality of care provided to Catherine Romero, it follows that South Davis should recover the costs of the patient's treatment at an acute care level or, at least, a skilled nursing care level. South Davis further contends that reimbursement should be made in accordance with a Medicare standard of payment which requires payment for services at the lesser of (A) reasonable cost of such services; or (B) the customary charges with respect to such services.[5] However, merely because South Davis provided necessary medical care, it does not follow that the State of Utah must expend already limited resources where South Davis failed to comply with both (A) physician's certification and recertification requirements and (B) the preadmission and continued stay criteria of intensity of service and severity of illness for acute care patient services.

A. Physician's Certification.

Federal law, as discussed above, requires a State Medicaid

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[5] See 42 U.S.C. § 1395f(b) (1992). However, for purposes of Medicaid cost reimbursement, Congress enacted 42 U.S.C. § 1396 et seq. (1992), which requires reimbursement to be made on a reasonable rate basis pursuant to diagnostically related group rates.

plan to provide methods and procedures to safeguard against unnecessary utilization of care and services by Medicaid providers and to assure that payments to those providers are consonant with efficiency, economy and quality of care. See 42 U.S.C. § 1396a(A)(30) (1992). As a central part of this utilization review program, Congress mandated that, whenever a Medicaid patient is admitted to either a nursing home or a hospital, a physician must certify and recertify at least every 60 days that the services being provided to the patient are or were required because the patient either needs or needed such services. See 42 U.S.C. §§ 1396a(44)(A), 1396b(g)(6)(A) (1990); 42 C.F.R. §§ 456.60, 456.260 (1992); State of Wisconsin, Dep't of Health & Social Services v. Bowen, 797 F.2d 391, 393 (7th Cir. 1986); Commonwealth of Virginia v. Bowen, 683 F. Supp. 148, 149 (W.D. Va. 1988); O'Keefe v. Bowen, 643 F. Supp. 523, 527 (E.D. N.Y. 1986).

If a state fails to make a satisfactory showing of physician certification and recertification, the Secretary of Health and Human Services will decrease federal matching funds available to the state. See State of Hawaii v. Heckler, 760 F.2d 1031, 1032 (9th Cir. 1985). As the court in Commonwealth of Virginia v. Bowen explained, the federal government must reduce the amount of federal financial participation ("FFP") granted to a State regardless of the state's self-policing procedures, i.e., utilization review, if physician's certification and recertification requirements are not met by a particular provider

in a given case. 683 F. Supp. at 153. This very real and harsh federal policy concerning financial penalties directly contradicts South Davis's assertion that the State of Utah will suffer no harm if it ignores the absence of physician's certification and recertification in this case.

Pursuant to Utah Admin. Code R455-9-6(T)(2) (1990), DHCF's no-payment policy regarding a provider's lack of physician certification has no exceptions. Addendum D at E-55-56. Additionally, R455-9-6(T)(3) (1990) states that if a provider does not follow the physician's certification requirement of the state's utilization review plan, "the provider will assume all liability for all incurred expenses for care and services of the patient/resident. The provider [may] not bill the patient/resident or other responsible party for care/service not reimbursed by Medicaid due to the provider's failure to follow the policy and procedure." Thus, it is the responsibility of a Medicaid provider to ensure that a physician certifies and recertifies a patient's need for a particular level of care.

In the instant case, there is nothing in Catherine Romero's medical record during the time in question which rises to the level of physician certification or recertification. In other words, there is no affirmative statement or prepared document by her physician which succinctly and clearly verifies that her medical condition required that she be treated at an acute level of care. The instant record is absolutely silent as to the level of care Catherine Romero required during this three-month period.

Moreover, as further evidence of South Davis's knowledge of its failure to satisfy the certification requirement during this period, South Davis presents a record of physician's certification and recertifications for the period of time *immediately following* the period in dispute which *does* satisfy utilization review procedures regarding certifications. See E-170-174. This requirement is straightforward and unambiguous. As a result, South Davis's blatant attempt to circumvent the requirement by pointing to the medical record in its entirety, replete with copious nursing notes and weekly doctors visits, is unpersuasive and meritless. The fact remains that South Davis failed to comply with an indispensable predicate for Medicaid reimbursement. Thus, South Davis is without excuse for failing to ensure the presence of a physician's certification and recertifications in Catherine Romero's medical record for the three-month period in question.

Consequently, such an omission bars DHCF from paying for any level of care of service rendered to Catherine Romero for this period. If it approved reimbursement regardless of the absence of certification, DHCF would be violating mandatory federal and state law on this subject.

B. Preadmission and Continued Stay Criteria.

Pursuant to Congress's intent, an effective program of utilization control must: (1) preserve already limited financial resources; and (2) ensure the quality and necessity of the level of care. State of Wisconsin v. Bowen, 797 F.2d at 394. In

general, when a patient is certified for a particular level of services, that patient must receive those services. Such is not the case with respect to Catherine Romero and the services provided by South Davis.

Besides the unavailability of physician's certification and recertification, South Davis failed to conform to the criteria set forth under both federal and state law for acute care inpatient hospital services. Specifically, pursuant to the Utah Admin. Code R455-9-1 (1989), entitled Preadmission/Continued Stay Review and Level of Care Criteria, "no applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care." See also Addendum D at E-93. In the instant case, DHCF determined Catherine Romero did not receive or need an acute level of care at South Davis during this disputed period, notwithstanding South Davis's appellate arguments and mischaracterizations to the contrary. Even assuming, arguendo, that South Davis complied with the certification and recertification prerequisites for payment, DHCF would be barred from reimbursing South Davis at an acute care level based on insufficient documentation regarding the intensity of service and severity of illness involving this patient. See Respondent's Exhibit No. 6, "Override Option I, Appropriateness Evaluation Protocol."

To the extent South Davis is challenging DHCF's factual findings that Ms. Romero neither received nor required acute

care, it has failed to marshall the evidence and demonstrate that these findings are unsupported by substantial evidence in the record. Notwithstanding this failure of South Davis to carry its burden, there is substantial support for DHCF's findings. Heinecke v. Dep't of Commerce, 810 P.2d 459, 464 (Utah App. 1991) (quoting Grace Drilling v. Board of Review, 776 P.2d 63, 68 (Utah App. 1989)).

Pursuant to its Superior Systems Waiver, DHCF applied specific criteria when reviewing this Medicaid record to determine whether acute care services were unnecessary. Those criteria are found in Override Option I, Appropriateness Evaluation Protocol. Respondent's Exhibit No. 6. At the Formal Hearing, two medical consultants assigned to the Department of Health, who reviewed the medical record, agreed that the same services provided to Catherine Romero in an acute care hospital setting for the three-month period in question could have been, and should have been, provided at a lesser level of care, and thus billed at a skilled nursing facility level I.

In fact, the services rendered for Ms. Romero were skilled, not acute services. Because the patient was in a chronic, yet stable, state DHCF's medical experts stated there had been no significant change in Catherine Romero's medical status in 22 months. As further evidence of this patient's stable medical condition over a protracted period of time, reference should be made to the History and Physical which formed the basis for Dr. Welling's (Catherine Romero's physician) authorization to

transfer Catherine to skilled level of care II on November 1, 1989. This was the same History and Physical upon which the physician relied for Ms. Romero's acute care placement beginning on September 9, 1987. See E-220.

Furthermore, Catherine Romero's condition requiring her to use a respirator was not a recent event or decision in her hospitalization. DHCF's physician consultant, Dr. John C. Hylen, testified that the criterion concerning respirator care for a patient needing acute care services refers to an individual who has been recently placed on a respirator and not someone, such as Ms. Romero, who had used a respirator continuously for a period of 22 months and is stable. R. at 14.

Pursuant to Utah Admin. Code R455-9-27(A)(4)(a) (1990), skilled nursing level of care is appropriate when "there is presently no reason that the patient can any longer benefit from care and services available in an acute care hospital that are not available in a skilled nursing facility." Addendum D at E-91. Therefore, since the acute care setting is not the only facility where patients routinely use respirators, evidence produced at the hearing established that patients on ventilators may be cared for at alternative, less intense, settings where their overall medical conditions do not warrant placement in an acute care facility.

The medical record further illustrates that Ms. Romero's condition and needs were such that she was not receiving and did not need acute care services. Her medical status did not change

substantially over a three-month period and thus, she could have been treated at a less intense and costly level of care.

A review of the medical record supports DHCF's findings that Catherine Romero's diagnosis and prognosis could have been treated at a less expensive, equally effective skilled nursing level of care. Allowing a skilled nursing patient to remain for three months in an acute care setting constitutes an inefficient use of state and federal funds and does not comport with federal mandates requiring responsible and economical placement of patients. Therefore, DHCF reasonably determined Medicaid reimbursement was not justified at an acute care level because Catherine Romero's condition required, and in fact, received skilled nursing and not acute care services.

CONCLUSION

For the foregoing reasons, DHCF's decision denying South Davis Medicaid reimbursement for the period of August 1, 1989 through October 31, 1989 should be affirmed.

RESPECTFULLY SUBMITTED this 11th day of August, 1993.

JAN GRAHAM
Attorney General

J. STEPHEN MIKITA
Assistant Attorney General
Human Services Division

MAILING CERTIFICATE

I hereby certify that I mailed four (4) copies of the foregoing Respondent's Brief, postage prepaid on this, the 11th day of August, 1993, to the following:

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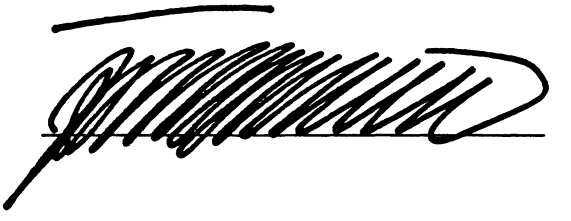

ADDENDUM A

need for the continued stay. If they find that the recipient no longer needs inpatient mental hospital services, their decision is final.

§ 456.237 Notification of adverse decision.

The UR plan must provide that written notice of any adverse final decision on the need for continued stay under § 456.236 (f) through (h) is sent to—

(a) The hospital administrator;

(b) The attending or staff physician;

(c) The Medicaid agency;

(d) The recipient; and

(e) If possible, the next of kin or sponsor.

§ 456.238 Time limits for final decision and notification of adverse decision.

The UR plan must provide that—

(a) The committee makes a final decision on a recipient's need for continued stay and gives notice under § 456.237 of an adverse decision within 2 working days after the assigned continued stay review date, except as required under paragraph (b) of this section.

(b) If the committee makes an adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice under § 456.237 within 2 working days after the date of the final decision.

UR Plan: Medical Care Evaluation Studies

§ 456.241 Purpose and general description.

(a) The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(b) Medical care evaluation studies—

(1) Emphasize identification and analysis of patterns of patient care; and

(2) Suggest appropriate changes needed to maintain consistently high quality patient care and effective and efficient use of services.

§ 456.242 UR plan requirements for medical care evaluation studies.

(a) The UR plan must describe the methods that the committee uses to select and conduct medical care evaluation studies under paragraph (b)(1) of this section.

(b) The UR plan must provide that the UR committee—

(1) Determines the methods to be used in selecting and conducting medical care evaluation studies in the mental hospital;

(2) Documents for each study—

(i) Its results; and

(ii) How the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;

(3) Analyzes its findings for each study; and

(4) Takes action as needed to—

(i) Correct or investigate further any deficiencies or problems in the review process; or

(ii) Recommend more effective and efficient hospital care procedures.

§ 456.243 Content of medical care evaluation studies.

Each medical care evaluation study must—

(a) Identify and analyze medical or administrative factors related to the mental hospital's patient care;

(b) Include analysis of at least the following:

(1) Admissions.

(2) Durations of stay.

(3) Ancillary services furnished, including drugs and biologicals.

(4) Professional services performed in the hospital; and

(c) If indicated, contain recommendations for change beneficial to patients, staff, the hospital, and the community.

§ 456.244 Data sources for studies.

Data that the committee uses to perform studies must be obtained from one or more of the following sources:

(a) Medical records or other appropriate hospital data.

(b) External organizations that compile statistics, design profiles, and produce other comparative data.

(c) Cooperative endeavors with—

(1) PROs;

(2) Fiscal agents;

(3) Other service providers; or

(4) Other appropriate agencies.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 43198, Dec. 1, 1986]

§ 456.245 Number of studies required to be performed.

The mental hospital must, at least, have one study in progress at any time and complete one study each calendar year.

Subpart E—Utilization Control: Skilled Nursing Facilities

§ 456.250 Scope.

(a) This subpart prescribes requirements for control of utilization of skilled nursing facility (SNF) services including requirements concerning—

(1) Certification of need for care;

(2) Medical evaluation and admission review;

(3) Plan of care;

(4) Utilization review plans; and

(5) Discharge plans.

§ 456.251 Definitions.

Skilled nursing facility services means those items and services defined in §§ 440.40 and 440.140 of this subchapter, but excludes those services if they are provided in Christian Science sanitoria.

Medical care criteria means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

Certification of Need for Care

§ 456.260 Certification and recertification of need for inpatient care.

(a) *Certification.* (1) A physician must certify for each applicant or recipient that SNF services are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a SNF, before the Medicaid agency authorizes payment.

(b) *Recertification.* (1) A physic or physician assistant or nurse pra tioner (as defined in § 491.2 of t chapter) acting within the scope practice as defined by State law under the supervision of a physic must recertify for each applicant recipient that SNF services needed.

(2) Recertification must be made least every 60 days after certificat

[46 FR 48561, Oct. 1, 1981; 46 FR 54 Nov. 4, 1981]

Medical, Psychiatric, and Socia Evaluations, and Admission Revi

§ 456.270 Medical, psychiatric, and so evaluations.

(a) Before admission to a SNF before authorization for payment, attending physician must make—

(1) A medical evaluation of each plicant's or recipient's need for car the SNF; and

(2) A plan of rehabilitation, wh applicable.

(b) In a SNF that cares primarily mental patients, appropriate pro sional personnel must make a psyc atric and a social evaluation of n for care.

(c) Each medical evaluation must clude—

(1) Diagnoses;

(2) Summary of present medi findings;

(3) Medical history;

(4) Mental and physical functio capacity;

(5) Prognoses; and

(6) A recommendation by a ph cian concerning—

(i) Admission to the SNF; or

(ii) Continued care in the SNF individuals who apply for Medic while in the facility.

§ 456.271 Medicaid agency review of r for admission.

Medical and other professional p sonnel of the Medicaid agency or designees must evaluate each ap cant's or recipient's need for admiss by reviewing and assessing the eval tions required by § 456.270.

§ 456.5 Evaluation criteria.

The agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. This section does not apply to services in hospitals, mental hospitals, and SNFs. For these facilities, see the following sections: §§ 456.122 and 456.132 of subpart C; § 456.232 of subpart D; and § 456.332 of subpart E.

§ 456.6 Review by State medical agency of appropriateness and quality of services.

(a) The Medicaid agency must have an agreement with the State health agency or other appropriate State medical agency, under which the health or medical agency is responsible for establishing a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services.

(b) The purpose of this review plan is to provide guidance to the Medicaid agency in the administration of the State plan and, where applicable, to the State licensing agency described in § 431.610.

Subpart B—Utilization Control: All Medicaid Services

§ 456.21 Scope.

This subpart prescribes utilization control requirements applicable to all services provided under a State plan.

§ 456.22 Sample basis evaluation of services.

To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

§ 456.23 Post-payment review process.

The agency must have a post-payment review process that—

(a) Allows State personnel to develop and review—

(1) Recipient utilization profiles;

(2) Provider service profiles; and

(3) Exceptions criteria; and

(b) Identifies exceptions so that the agency can correct misutilization practices of recipients and providers.

Subpart C—Utilization Control: Hospitals

§ 456.50 Scope.

This subpart prescribes requirements for control of utilization of inpatient hospital services, including requirements concerning—

(a) Certification of need for care;

(b) Plan of care; and

(c) Utilization review plans.

§ 456.51 Definitions.

As used in this subpart:

Inpatient hospital services—

(a) Include—

(1) Services provided in an institution other than an institution for mental disease, as defined in § 440.10;

(2) [Reserved]

(3) Services provided in specialty hospitals and

(b) Exclude services provided in mental hospitals. Utilization control requirements for mental hospitals appear in subpart D.

Medical care appraisal norms or *norms* means numerical or statistical measures of usually observed performance.

Medical care criteria or *criteria* means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 22041, June 17, 1986]

Certification of Need for Care

§ 456.60 Certification and recertification of need for inpatient care.

(a) *Certification.* (1) A physician must certify for each applicant or recipient that inpatient services in a hospital are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(b) *Recertification.* (1) A physician, or physician assistant or nurse practitioner (as defined in § 491.2 of this chapter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that inpatient services in a hospital are needed.

(2) Recertifications must be made at least every 60 days after certification.

[46 FR 48561, Oct. 1, 1981]

Plan of Care

§ 456.80 Individual written plan of care.

(a) Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written plan of care for each applicant or recipient.

(b) The plan of care must include—

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Any orders for—

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Social services;

(vi) Diet;

(4) Plans for continuing care, as appropriate; and

(5) Plans for discharge, as appropriate.

(c) Orders and activities must be developed in accordance with physician's instructions.

(d) Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.

(e) A physician and other personnel involved in the recipient's case must review each plan of care at least every 60 days.

Utilization Review (UR) Plan: General Requirement

§ 456.100 Scope.

Sections 456.101 through 456.145 of this subpart prescribe requirements for a written utilization review (UR) plan for each hospital providing Medicaid services. Sections 456.105 and 456.106 prescribe administrative requirements: §§ 456.111 through 456.113 prescribe informational requirements; §§ 456.121 through 456.129 prescribe requirements for admission review; §§ 456.131 through 456.137 prescribe requirements for continued stay review; and §§ 456.141 through 456.145 prescribe requirements for medical care evaluation studies.

§ 456.101 UR plan required for inpatient hospital services.

(a) A State plan must provide that each hospital furnishing inpatient services under the plan has in effect a written UR plan that provides for review of each recipient's need for the services that the hospital furnishes him.

(b) Each written hospital UR plan must meet the requirements under §§ 456.101 through 456.145.

UR Plan: Administrative Requirements

§ 456.105 UR committee required.

The UR plan must—

(a) Provide for a committee to perform UR required under this subpart;

(b) Describe the organization, composition, and functions of this committee; and

(c) Specify the frequency of meetings of the committee.

§ 456.106 Organization and composition of UR committee; disqualification from UR committee membership.

(a) For the purpose of this subpart, "UR committee" includes any group organized under paragraphs (b) and (c) of this section.

(b) The UR committee must be composed of two or more physicians, and assisted by other professional personnel.

(c) The UR committee must be constituted as—

(1) A committee of the hospital staff;

(2) A group outside the hospital staff, established by the local medical or osteopathic society and at least some of the hospitals and SNFs in the locality;

(3) A group capable of performing utilization review, established and or-

need for the continued stay. If they find that the recipient no longer needs inpatient mental hospital services, their decision is final.

§ 456.237 Notification of adverse decision.

The UR plan must provide that written notice of any adverse final decision on the need for continued stay under § 456.236 (f) through (h) is sent to—

(a) The hospital administrator;

(b) The attending or staff physician;

(c) The Medicaid agency;

(d) The recipient; and

(e) If possible, the next of kin or sponsor.

§ 456.238 Time limits for final decision and notification of adverse decision.

The UR plan must provide that—

(a) The committee makes a final decision on a recipient's need for continued stay and gives notice under § 456.237 of an adverse decision within 2 working days after the assigned continued stay review date, except as required under paragraph (b) of this section.

(b) If the committee makes an adverse final decision on a recipient's need for continued stay before the assigned review date, the committee gives notice under § 456.237 within 2 working days after the date of the final decision.

UR Plan: Medical Care Evaluation Studies

§ 456.241 Purpose and general description.

(a) The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care.

(b) Medical care evaluation studies—

(1) Emphasize identification and analysis of patterns of patient care; and

(2) Suggest appropriate changes needed to maintain consistently high quality patient care and effective and efficient use of services.

§ 456.242 UR plan requirements for medical care evaluation studies.

(a) The UR plan must describe the methods that the committee uses to select and conduct medical care evaluation studies under paragraph (b)(1) of this section.

(b) The UR plan must provide that the UR committee—

(1) Determines the methods to be used in selecting and conducting medical care evaluation studies in the mental hospital;

(2) Documents for each study—

(i) Its results; and

(ii) How the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;

(3) Analyzes its findings for each study; and

(4) Takes action as needed to—

(i) Correct or investigate further any deficiencies or problems in the review process; or

(ii) Recommend more effective and efficient hospital care procedures.

§ 456.243 Content of medical care evaluation studies.

Each medical care evaluation study must—

(a) Identify and analyze medical or administrative factors related to the mental hospital's patient care;

(b) Include analysis of at least the following:

(1) Admissions.

(2) Durations of stay.

(3) Ancillary services furnished, including drugs and biologicals.

(4) Professional services performed in the hospital; and

(c) If indicated, contain recommendations for change beneficial to patients, staff, the hospital, and the community.

§ 456.244 Data sources for studies.

Data that the committee uses to perform studies must be obtained from one or more of the following sources:

(a) Medical records or other appropriate hospital data.

(b) External organizations that compile statistics, design profiles, and produce other comparative data.

(c) Cooperative endeavors with—

(1) PROs;

(2) Fiscal agents;

(3) Other service providers; or

(4) Other appropriate agencies.

[43 FR 45266, Sept. 29, 1978, as amended at 51 FR 43198, Dec. 1, 1986]

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The mental hospital must, at least, have one study in progress at any time and complete one study each calendar year.

Subpart E—Utilization Control: Skilled Nursing Facilities

§ 456.250 Scope.

(a) This subpart prescribes requirements for control of utilization of skilled nursing facility (SNF) services including requirements concerning—

(1) Certification of need for care;

(2) Medical evaluation and admission review;

(3) Plan of care;

(4) Utilization review plans; and

(5) Discharge plans.

§ 456.251 Definitions.

Skilled nursing facility services means those items and services defined in §§ 440.40 and 440.140 of this subchapter, but excludes those services if they are provided in Christian Science sanitoria.

Medical care criteria means predetermined elements against which aspects of the quality of a medical service may be compared. These criteria are developed by health professionals relying on their expertise and the professional health care literature.

Certification of Need for Care

§ 456.260 Certification and recertification of need for inpatient care.

(a) *Certification.* (1) A physician must certify for each applicant or recipient that SNF services are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a SNF, before the Medicaid agency authorizes payment.

(b) *Recertification.* (1) A physician, or physician assistant or nurse practitioner (as defined in § 491.2 of this chapter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that SNF services are needed.

(2) Recertification must be made at least every 60 days after certification.

[46 FR 48561, Oct. 1, 1981; 46 FR 54744, Nov. 4, 1981]

Medical, Psychiatric, and Social Evaluations, and Admission Review

§ 456.270 Medical, psychiatric, and social evaluations.

(a) Before admission to a SNF or before authorization for payment, the attending physician must make—

(1) A medical evaluation of each applicant's or recipient's need for care in the SNF; and

(2) A plan of rehabilitation, where applicable.

(b) In a SNF that cares primarily for mental patients, appropriate professional personnel must make a psychiatric and a social evaluation of need for care.

(c) Each medical evaluation must include—

(1) Diagnoses;

(2) Summary of present medical findings;

(3) Medical history;

(4) Mental and physical functional capacity;

(5) Prognoses; and

(6) A recommendation by a physician concerning—

(i) Admission to the SNF; or

(ii) Continued care in the SNF for individuals who apply for Medicaid while in the facility.

§ 456.271 Medicaid agency review of need for admission.

Medical and other professional personnel of the Medicaid agency or its designees must evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by § 456.270.

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lary" with all the attendant restrictions which were in effect prior to Nov. 1, 1984. In addition, the Committee agrees to actively support and participate in re-evaluating and restructuring the Pharmacy Program with appropriate program controls.
1987 26-1-5

R455-7. Medicaid Policy for Experimental/Unproven Medical Practices

R455-7-1. Policy

R455-7-1. Policy

1. Unproven medical practices shall not be a benefit of the Medicaid Program. Unless billed services are proven to be medically efficacious as determined by HCFA* for Medicare coverage, payment shall be denied by Medicaid. This includes any services which are investigational or experimental in nature and/or are performed in conjunction with or by persons who are using such services to generate data to support or contribute in any way to research grants, studies or projects, or testing of new processes or products, regardless of sources of support or funding for such projects or any parts of such projects.

2. If such services are billed to and paid by Medicaid, payments for the services in question, along with payments for all supporting services (although not in themselves, experimental) shall be refunded to the Medicaid Program. Supporting services may include, but are not limited to supplies, laboratory, x-ray, inpatient/outpatient hospitalization; physician, pharmacy, therapist or transportation.

3. Although some services have been shown to provide some medical benefit for certain medical conditions, such services shall not be covered for other conditions unless medical efficacy is proven in accordance with the requirements of paragraph 1 (above). Examples of such medically unproven treatments include, but are not limited to, plasmapheresis in multiple sclerosis and renal dialysis in schizophrenia.

*Final determination is made by the Special Coverage Issues Bureau, Bureau of Eligibility, Reimbursement, and Coverage, Health Care Financing Administration, Department of Health and Human Services, 6324 Security Blvd., Baltimore, Maryland 21207, phone (301) 594-6719.
1987 26-1-5

R455-8. Chiropractors' Services

R455-8-1.

R455-8-1.

Pursuant to Utah Code Annotated, Second Replacement, Volume 7A, 1983 "Pocket Supplement" Section 63-46-5.7, State agencies are required to review their rule-making at five year intervals. This rule-making reaffirms the continuation of policy expressed in adopted rule MA-79-7 (Archives Accession Number 3206): Chiropractic Services are not a benefit under Medicaid. This rule will therefore continue for another 5 year period unless repeal action is taken. There is no fiscal impact anticipated as a result of this continuation of policy.
1987 26-1-5

R455-9. Preadmission/Continued Stay Review and Level of Care Criteria

R455-9-1. Policy

R455-9-1. Policy

Attached are the revised level of care criteria for Medicaid coverage of Intermediate-II level of care services provided in nursing care facilities. These attached criteria will replace pages 10 and 11 of the previous rulemaking, UDH-HCF-85-17.

The attached criteria requires that the Patient Assessment Section receive and approve the specific level of care before any Medicaid coverage can be authorized. The authorization for care is based upon the applicant's/recipient's severity of illness, intensity of service needed, anticipated outcome, and setting for service.

The Patient Assessment Section will continue to utilize the Preadmission/Continued Stay Inpatient Care Transmittal-Form 10/A as the prior authorization document. Completion of this form is contingent on information obtained from the certification of need for inpatient care, medical, psychological and social evaluations, exploration of alternative services and individual written plan of care, which are required before admission to the nursing care facility as specified in Title 42 of the Code of Federal Regulations Part 456, Subparts E and F.

The provider may submit copies of the comprehensive medical evaluation, nursing care assessment, social services evaluation and interdisciplinary plan of care in lieu of filling out the sections of the Form 10/A which document the medical review, nursing assessment and social services evaluation. The provider is still required to submit the Preadmission/Continued Stay Inpatient Care Transmittal and the Patient/Resident Release of Information Form with all required documentation whenever there is a request for Medicaid reimbursement authorization.

The Patient Assessment Section may require additional documentation to complete the preadmission assessment process.

Definitions - The following definitions apply to terms used throughout the attached criteria:

Active Treatment means training and habilitation services defined in Title 42 Code of Federal Regulations, Section 435.1009 and Section 442.463, which are intended to aid the individual in intellectual, sensorimotor, and emotional development.

These regulations are hereby adopted by reference.

Active Treatment is applicable only to individuals with a diagnosis of mental retardation or developmental disability.

Activities of Daily Living (ADLs) means the care normally provided for oneself in a normal lifestyle. Also includes adaptation to the use of assistive devices and prostheses intended to provide the greatest degree of independent functioning. This definition also takes into account a person's own perception of what constitutes an adequate lifestyle.

Applicant/Recipient means an applicant is an individual who has filed an application for the purpose of obtaining eligibility for the Medicaid program.

A recipient is an individual who has been deemed, by authorized Medicaid personnel, to meet the eligibility requirements for Medicaid benefits.

Appropriate Services means those services directly related to the applicant/recipient's identified needs

given in a timely manner and in sufficient quantity and quality to improve or maintain the person's condition.

Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs. Also refer to definition for Active Treatment.

Behavior Management means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of reducing observable negative behaviors. All behavior management programs must:

a) Incorporate processes and methodologies which are the "least restrictive alternatives" available for producing the desired outcomes;

b) Be conducted only following identification (and if feasible, remediation) of environmental and social factors which are likely to be precipitating or reinforcing the inappropriate behavior;

c) Incorporate a process for identifying and reinforcing a desirable replacement behavior;

d) Behavior management programs provided in ICF/MRs must meet the requirements of Title 42 Code of Federal Regulations Section 442.441.

All behavior management programs must include the following elements:

a. Behavior Baseline Profile, consisting of:

1. client's name

2. specific description of the undesirable behavior exhibited

3. condition(s) existing prior to and at the time of the undesirable behavior

4. date, time, location of incident(s)

5. individuals present during incident(s)

6. interventions used

7. results of interventions

8. recommendations for future action

b. Behavior Management Plan, consisting of:

1. client's name

2. objectives stated in terms of specific behaviors

3. date of inception of program

4. when program will be used

5. names, titles, signatures of the individuals responsible for conducting the program

6. data collection methods

7. methods and frequency of data review

c. Program Data Sheet, consisting of:

1. client's name

2. objective identified

3. date, time, location of behavior

4. client response to specific steps in the behavior management plan

5. signature or initials of individual conducting the program

Comprehensive Evaluation - ICF means a medical and social evaluation of each person's need for care in an intermediate care facility, completed by the facility's interdisciplinary team of health professionals.

Based upon diagnosis, signs and symptoms, a current psychiatric and/or psychological evaluation is also completed by an appropriate health professional.

Each evaluation must include:

a. Diagnosis;

b. Summary of present medical, social and, where appropriate, developmental findings;

c. Medical and social family history;

d. Mental and physical functional capacity;

e. Prognoses;

f. Kind(s) of service(s) needed;

g. Evaluation, by a worker employed by the Department of Social Services, of the resources available in the home, family and community; and

h. An evaluation, by a worker employed by the Department of Social Services, which recommends either:

1. Admission to an intermediate care facility, or

2. Continued care in the intermediate care facility for persons who apply for Medicaid while in the intermediate care facility.

Comprehensive Evaluation-SNF means the facility's attending physician must make:

1. A medical evaluation of each applicant's or recipient's need for care in the SNF;

2. A plan of rehabilitation, where applicable; and

3. A psychiatric and a social evaluation of need for care for any applicant/recipient with a diagnosis of mental illness.

Each evaluation must include:

a. Diagnosis;

b. Summary of present medical, social and, where appropriate, developmental findings;

c. Medical and social family history;

d. Mental and physical functional capacity;

e. Prognoses;

f. Kind(s) of service(s) needed;

g. A recommendation by a physician concerning either:

1. Admission to skilled nursing care facility, or

2. Continued care in the skilled nursing care facility for persons who apply for Medicaid while in the skilled nursing care facility.

Day Treatment means training and habilitation services delivered outside the ICF/MR which are:

a. Intended to aid the vocational, pre-vocational and/or self-sufficiency skill development of a qualified ICF/MR recipient;

b. Sufficient to meet the active treatment requirements of Title 42 Code of Federal Regulations, Section 435.1009 and Section 442.463; and

c. Fully coordinated with and integrated with the active treatment program of the ICF/MR.

Developmental Programming means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching or maintaining behaviors. Developmental Programming is based upon the same principles as Behavior Management (see above). However, Developmental Programming specifically refers to teaching adaptive behavior skills to improve individual personal and social development.

Discharge Plan means a plan which must insure that the applicant/recipient has an individualized planned program of post-discharge continuing care.

The discharge plan must:

1. State the medical, functional, behavioral, and social levels necessary for the applicant/recipient to be discharged to a less restrictive setting;

2. Include steps needed to move applicant/recipient to a less restrictive setting;

3. Establish the feasibility of the patient achieving the levels necessary for discharge; and

4. State the anticipated time frames for that achievement.

Governing Principles means the principles which govern Bureau determinations regarding eligibility for and provision of ICF/MR services, Medicaid reimbursement, hearings, and court actions. These principles include:

1. The developmental imperative: The natural

impulse in all persons is toward growth and development, and will be expressed given the right kind of environmental stimulation. Therefore, MR/DD persons are capable of growth and development throughout their lives.

2. The active treatment imperative: In order to fullfill the MR/DD person's potential for growth and development, ICF/MR services must actively address identified treatment needs, not simply provide custodial care.

3. Normalization: ICFs/MR should provide the opportunity for lifestyles which are set in the context of normal community life and which are as similar as possible to the typical cultural and community norms for the recipients' particular age group.

4. Integration: ICF/MR services should be integrated into the community, and should be no larger than that which the surrounding community can readily integrate into recreation, transportation, shopping, education, employment and socialization resources.

5. Separation: ICF/MR facilities should be primarily habilitative in nature, with other services such as education, work, medical treatment, and most recreational activities delivered out of home in regular community settings, as is the case for non-handicapped persons.

6. Specialization: ICF/MR facilities should specialize as much as possible according to similar resident needs. Thus, placement of divergent age groups or groups requiring distinctly different types of environments should be avoided.

7. Continuity: ICF/MR facilities should be part of a continuum of services, so that many options exist to meet the individual needs of the persons served.

8. Least Restrictive Environment: All persons have a basic right to live and work in the mainstream of society. Any separation from normal community life-styles in order to receive special services may be restrictive in several ways:

(a) by causing society to view the person as different, deviant, or even undesirable;

(b) by restricting opportunities for the person to learn and to interact freely with others;

(c) by causing labeling and segregation which injures the person's chance to be self-supporting and integrated into the mainstream.

Therefore, all persons should receive special services in settings which minimize separation from typical community life-styles. For the purposes of this rule, ICF/MR care is defined as more restrictive than that delivered in natural family homes, the person's own home, foster homes, board and care homes, and group homes.

9. Evaluation: Developmental testing for purposes of Medicaid reimbursement should be performed with recognized and standardized instruments that are appropriate to the person's age and level of functioning.

10. Training: Skills training and behavior modification used in ICF/MR settings should be delivered in a programming format which is based upon the principals of task analysis, appropriate reinforcement, consistency, and continuous assessment.

11. Need: In a system of limited resources, the most severely handicapped individuals should be given the highest priority for Medicaid services, in line with their greater treatment needs.

12. Purpose: The purpose of ICF/MR services is to provide a living situation which allows each person to maximize his/her ability to function as an accepted member of the community.

13. Rights: ICF/MR applicants/recipients are entitled to the same rights which are constitutionally afforded to all citizens.

Mental Retardation/Developmental Disability (MR/DD) means mental retardation is significantly subaverage intellectual functioning resulting in or associated with concurrent impairment(s) in adaptive behavior and manifest during the developmental period.

a. Significantly subaverage intellectual functioning is defined as a score of two or more standard deviations below the mean on a standardized general intelligence test.

b. Developmental period is defined as the period of time between conception and the eighteenth birthday.

Developmental disability means a severe, chronic disability that meets all of the following conditions:

(1) Is attributable to -

(a) Cerebral palsy, epilepsy; or

(b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(2) Is manifest before the person reaches age 22;

(3) Is likely to continue indefinitely; and

(4) Results in substantial functional impairments in three or more of the specified areas of major life activity (See Substantial Functional Impairment)

Plan of Care means before admission to a Skilled Nursing Facility, or an Intermediate Care Facility (including ICF/MR), or before the effective date of authorization for payment for such services, the attending physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

1. Diagnoses, symptoms, complaints or complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Measurable objectives describing the desired future medical, functional and social status of the patient;

4. Time frames for achieving objectives;

5. Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

6. Plans for continuing care, including review and modification to the plan of care; and

7. Plans for discharge (see definition for Discharge Plan).

The attending or staff physician and other personnel involved in the person's plan of care, including the interdisciplinary team in an ICF, must review and update each plan of care at least every 60 days for skilled patients and at least every 90 days for intermediate patients.

Substantial Functional Impairment means demonstrable limitations which render the applicant/recipient incapable of reasonably performing three or more of the following major life activities:

1. Self-care,

2. Understanding and use of language,

3. Learning,

4. Mobility,

5. Self-direction, (e.g., decision making, goal orientation, exercising civil rights, etc.),

6. Capacity for independent living.

Preadmission/Continued Stay Part A, Attachment A-1(a)

Criteria for Intermediate Care - II

Intermediate level of care means: In accordance with Title 42 of the Code of Federal Regulations Part 442, Section 251 the following requirements apply:

An ICF must provide, on a regular basis, health-related care and services to individuals who do not require hospital or skilled care, but whose mental or physical condition requires services:

1. Above the level of room and board; and

2. That can be provided only by an institution.

Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs.

Authorization for Medicaid reimbursement at one of the Intermediate Care levels (ICF-I and II levels of care) is made only after review of Comprehensive Evaluation documentation which demonstrates that the applicant/recipient's medical needs cannot be met, and the health status cannot be maintained, through the use of one or more of the following resources which are appropriate and available to the individual:

1. Outpatient physician services
2. Other outpatient medical services
3. Family
4. Volunteers
5. Chore services
6. Homemaking Services
7. Diet and Nutrition
8. Socialization
9. Recreation
10. Transportation
11. Economic Assistance
12. Legal Assistance
13. Counseling
14. Mental Health Services
15. Social Support Services
16. Housing Assistance
17. Handicapped Services
18. Services provided when applicable under Titles III, IV, VI, XVIII & XX
19. Home and community based services
20. Home Health
21. Personal Care Services
22. Other resources as appropriate and available

(NOTE: If the intensity of services given or needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that meets the definition of a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.)

Preadmission/Continued Stay - Part A Attachment A-1(b)(1)

Criteria for Intermediate Care II

The Patient Assessment Section will utilize the following elements to determine that the applicant/recipient has mental or physical conditions which require services above the level of room and board and that can be provided only in an institution. the request for Medicaid approval must document that the applicant/recipient has two or more of the following elements:

1. Due to documented diagnosed medical conditions, the applicant/recipient requires total care and/or substantial physical assistance with activities of daily living. Substantial physical assistance as defined in this policy means assistance above the level of: verbal prompting (reminding), supervision, or set up.

2. The Consultive committee determines from submitted documentation that the attending physician has determined that the applicant/recipient's level of dysfunction in orientation to person, place and/or time requires institutional care.

3. The Consultive Committee has determined from documentation submitted that the medical condition and intensity of services is such that the care needs of the patient cannot be safely met in a less structured setting. There must be documentation that alternatives have been explored, utilized and why alternatives are not feasible.

4. The applicant/recipient has a diagnosis of mental retardation/developmental disability, but primarily requires medical management and services from an intermediate care facility rather than habilitation and training services from an intermediate care facility for the mentally retarded, as determined by the Consultive Committee.

In addition, before an applicant/recipient may be authorized for Medicaid coverage at the Intermediate II level of care, the following must take place:

a. A physical examination shall be completed within 30 days before, or seven days after, admission. (NHR & REGS. Ch 5 5.102 PG 5.1).

b. A comprehensive nursing assessment has been completed by licensed nursing personnell.

c. A social services evaluation has been completed by appropriate qualified staff. Appropriate qualified staff is defined as a Social Service worker licensed as SSW or higher licensure and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart E.

d. Before admission or authorization for payment, a physician must establish a written plan of care which must include: the need for admission; a description of the functional level of the individual; objectives and any orders for medications, treatments, restorative and rehabilitative services; activities; therapies, social service, diet and special procedures designed to meet the objective of the plan of care; plans for continuing care, including review and modification of the care; and plans for discharge. 42 CFR 456.380.

e. As determined necessary and appropriate by the Consultive Committee, a psychological or psychiatric evaluation has been completed by appropriate qualified staff and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart F, in addition to the required medical and social evaluations.

f. Any applicant/recipient with a diagnosis that is coded within the ICD-9-CM's phychiatric code range (291.0 through 316.) must have documentation submitted indicating that an Interdisciplinary Team (IDT) has met to determine the need for a behavior management plan. If the IDT determines that a behavior management plan is necessary, a plan must be submitted that follows the guidelines listed under "Behavior Management" in the Department of Health, Nursing Care Facility Regulations (5.219) and in this document. If the IDT determines that a behavior management plan is unnecessary, adequate documentation must be submitted to the Consultive Committee supporting the determination.

g. There is adequate documentation of all previous less restrictive alternatives/services utilized to prevent or defer institutional care as specified on Page 1 of these criteria.

h. The applicant/recipient must require and receive a minimum of 2.0 hours of direct care and

observation every 24 hours. A minimum of 20% of the 2.0 hours of care must be provided by licensed practical nurses and/or registered nurses.

NOTE: If the intensity of serivces given or needed meets the criteria for skilled care as defined under Attachment A-1(c) (State Rulemaking UDH-HCF-85-17), the applicant/recipient must be placed in a facility that is certified as a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

Continued Stay review will be conducted to:

a. Determine that the patient has shown significant imporvement to enforce Discharge Planning.

b. Determine need for continued stay in a Long Term Care facility.

Preadmission/Continued Stay - Part A Attachment A-1(b)(2)

Criteria for Intermediate Care I

The applicant/recipient must meet all the criteria for intermediate care, and the required intensity of services needed must be less than that which meets the criteria for skilled care services.

Also, the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 25% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

In addition to meeting the criteria for intermediate care, the applicant/recipient must have documented service needs for one or more of the following:

1. Daily rehabilitative or restorative services provided under the direction of licensed professional staff, with documented measurable outcomes of treatment.

2. Close observation, documentation and follow-through to establish the impact of specified care services, which may include but are not limited to: services to patients with neurological involvement, hospice services, diabetes control, and dialysis; any of which may utilize laboratory services and physician intervention.

3. Documented training in personal care services to minimize dependency on staff for completion of activities for daily living.

4. Documented behavior management/modification program established because of specified aberrant behavior such as wandering, excessive sexual drive, destructive or aberrant acting out, prolonged depression leading to self-isolation or violent acts.

5. Specialized nursing services for skin and wound care, which does not qualify for skilled level of care.

6. Extensive interaction with professional staff to assist applicant/recipient and family through final stages of death and dying. Maximum allowable time is three months prior to the anticipated death.

7. Any skilled service listed under the skilled criteria, ordered and given more than two times each week but less frequently than required for skilled care.

NOTE: If the intensity of services needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that meets the definition of a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

Preadmission/Continued Stay Part A, Attachment A-1(c)

Criteria for Skilled Care II

Skilled level of care means as duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.40(a): Skilled nursing facility services:

(1) Skilled nursing facility for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases, means services that are:

i. needed on a daily basis and required to be provided on an inpatient basis as defined in Title 42 of the Code of Federal Regulations Part 409, Section 31 through Section 35.

ii. provided by (A) a facility or distinct part of a facility that is certified to meet the requirements for participation under Title 42 of the Code of Federal Regulations Part 442, Subpart C, as evidenced by a valid agreement between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or (B) if specified in the State plan, a swing bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

iii. ordered by and provided under the direction of a physician.

(2) Skilled nursing facility services include services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Title 42 of the Code of Federal Regulations Part 405, Subpart K.

As duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.170(d): Skilled nursing facility services:

Skilled nursing facility services for indiviudals under 21 means those services specified in Title 42 of the Code of Federal Regulations, Part 440, Section 440.40 that are provided to recipients under 21 years of age.

In order to qualify for Medicaid skilled reimbursement, the applicant/recipient must have utilized the full scope of benefits for Medicare skilled nursing care or have been denied by Medicare for reasons other than the level of care requirements, i.e., the patient does not have a qualifying hospital stay in order to restart the benefit period.

In addition, the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 30% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.31: Level of care requirement, the following apply:

(a) Definition: As used in this section, "skilled nursing and skilled rehabilitation services" means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements:

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition:

(i) For which the beneficiary received inpatient hospital services; or

(ii) Which arose while the beneficiary was receiving care in a skilled or swing-bed hospital for a condition for which he or she received inpatient hospital services.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a skilled nursing facility, on an inpatient basis.

In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.32: Criteria for skilled services and the need for skilled services, the following requirements apply:

(a) The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled (such as those listed in 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in 409.33.

In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.33: Examples of skilled nursing and rehabilitation services, the following requirements apply:

(a) Services that could qualify as either skilled nursing or skilled rehabilitation services:

(1) Overall management and evaluation of care plan. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. This would include the management of a plan involving only a variety of personal care services when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. For example, an aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment for additional medical procedures until his or her condition is stabilized. For example, a patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) which serve as indicators for adjusting therapeutic measures. Likewise, surgical patients transferred from a hospital to a skilled nursing facility while in the complicated, unstabilized postoperative period, e.g., after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications, and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and/or the safety of others, i.e., to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders and/or nursing or therapy notes.

(3) Patient education services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance. For example, a patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Likewise, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions, etc.

(b) Services that qualify as skilled nursing services:

(1) Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

(2) Levin tube and gastrostomy feedings;

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

(c) Services which would qualify as skilled rehabilitation services:

(NOTE: All services must comply with the requirements for direct supervision as defined in State Medicaid Plan.)

(1) Ongoing assessment of rehabilitation needs and potential - Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities - Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training - Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises - Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy - Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning;

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions:

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator:

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.34: Criteria for "daily basis", the following requirements apply:

(a) To meet the daily basis requirement specified in 409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) As an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

(3) A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.35: Criteria for "practical matter", the following requirements apply:

General considerations - In making a "practical matter' determination, as required by 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare [and Medicaid] payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a Physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $100 of services furnished by such a practitioner in a year. This limitation of payment may not be a basis for finding that the needed care can only be provided in a skilled nursing facility.

(b) Examples of circumstances that meet practical matter criteria;

(1) Beneficiary's condition - Inpatient care would be required "as a practical matter" if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an

excessive physical hardship.

(2) Economy and efficiency - Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

Preadmission/Continued Stay Part A, Attachment A-1(d)

Criteria for Skilled Care-I

The applicant/recipient must meet all the criteria for skilled care. In addition, the applicant/recipient must meet all of the following conditions:

1. The applicant/recipient must have utilized the full scope of benefits for skilled nursing care under Medicare or have been denied by Medicare for reasons other than the level of care requirements, i.e., the patient does not have a qualifying hospital stay in order to restart the benefit period.

2. The applicant/recipient must require and receive a minimum of 5.0 hours of direct care and observation every 24 hours.

3. A minimum of 75% of the 5.0 hours of care must be provided by licensed practical nurses and/or registered nurses and shall include an aggregate of specialized care and services, patient instruction, etc., which can only be provided by licensed professionals.

4. The attending physician has made the following determinations on which to base his written orders:

a. There is presently no reasonable expectation that the patient can any longer benefit from any care and services available in an acute care hospital that are not available in a skilled nursing care facility;

b. The patient's condition requires physician follow-up at the skilled nursing care facility at a minimum of once every 30 days;

c. A leave of absence from the nursing care facility is medically contraindicated due to the patient's medical condition, unless a leave is necessary for the patient to undergo medical tests at an inpatient hospital.

5. The applicant's/recipient's needs for care, service, and supplies must meet all the following conditions both to qualify the applicant/recipient for Skilled Care-I and to qualify for Medicaid reimbursement at the Skilled Care-I level:

a. Be ordered by a physician;

b. Be required, necessary and appropriate for specialized and complex care;

c. Each and every qualifying service must be verifiable based on adequate documentation in the applicant's/recipient's medical record.

6. Except as otherwise provided, the applicant/recipient shall have been hospitalized immediately prior to admission to the skilled nursing care facility.

7. The applicant/recipient must have been continuously approved for skilled level of care, either through Medicare or Medicaid, since admission to the skilled nursing facility.

8. The attending physician's progress notes must be written and signed at the time of each physician visit and reflect the current medical status and condition of the patient.

The patient previously approved for Skilled Care-I payment and subsequently downgraded to a lesser level of payment may be returned to the Skilled Care-I category rather than being hospitalized in an acute care setting if:

1. An exacerbation or complication occurs involving the applicant's/recipient's condition for which they were originally approved for Skilled Care-I;

2. The applicant/recipient meets all criteria contained in 1 through 8 above, except that there is no discharge from the hospital; and

3. It has been less than 30 days since the termination of the previous Skilled Care-I contract.

The following services are considered routine skilled care and services, and are excluded from the criteria for Skilled Care-I level:

1. The skilled nursing services described in Attachment A-1(c), 409.33(b);

2. The skilled rehabilitation services described in Attachment A-1(c), 409.33(c);

3. Routine monitoring of medical gases after a regimen of therapy has been established;

4. Routine levin tube and gastrostomy feedings; and

5. Routine isolation room and techniques.

Preadmission/Continued Stay Part A, Attachment A-1(e)

Limitations on Medicaid Reimbursement for Services Provided by a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF)

Exclusions - Any applicant/recipient whose health, rehabilitative, and social needs may be reasonably met through alternative non-institutional services will be denied reimbursement for care in a skilled and intermediate care facility.

No applicant/recipient shall be approved for Medicaid reimbursement for skilled or intermediate level services if, as a practical matter, all his/her care and treatment needs can be met through alternative non-institutional services. This exclusion does not apply if the cost of care through alternative non-institutional services is higher than the cost of care in an intermediate care facility.

Consideration will be given to the feasibility of using more economical alternative facilities and services in making this exclusion. However, availability of Medicaid reimbursement for alternative services will not be a factor.

Example - An applicant's/recipient's needs can all be met in a supervised residential setting or in a group home. Medicaid reimbursement is not available for residential or group home placement. This limitation on payment may not be a basis for finding that the needed care can only be provided in a skilled or intermediate care facility.

Limitations on Level of Care - Reimburseable levels of care are here ranked in order of intensity from the least intense to the most intense:

1. Intermediate Care II
2. Intermediate Care I
3. Skilled Care-II
4. Skilled Care-I

No applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care.

Example - An applicant/recipient has extremely fragile skin, but this problem has been appropriately managed with no occurrences of decubitus or skin tears in either an intermediate care facility or at the intermediate level of care in a SNF. Reimbursement at the SNF level will not be approved.

Preadmission/Continued Stay Part A, Attachment A-1(f)

Criteria for Approval of Medicaid Reimbursement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

The purpose of the following criteria is two-fold - First, to assure that the applicant/recipient meets the criteria for Levels of Care as well as to verify qualifications to receive Medicaid reimbursement for ICF/MR services, and second, to specify the serv-

ices and outcomes which are required to qualify for the rate of reimbursement to ICF/MR residents for the three separate levels of ICF/MR care.

The three ICF/MR levels represent a range of severity of handicap and intensity of service needs which form the basis for Active Treatment. Level IMR-I represents the most severe level, and Level IMR-III represents the least severe level. In accordance with the Governing Principle of Need, the highest rate of reimbursement will be paid for Level IMR-I care, and the lowest rate for Level IMR-III care.

I. Level of Care IMR-I: Medicaid reimbursement for care and services at IMR-I level in an ICF/MR is limited to persons who are MR/DD as defined in this rule and who have one or more of the following conditions:

a. Is severely or profoundly retarded;

b. Is under six years of age;

c. Is severely multiply handicapped (has two or more of the conditions specified in the definition of mental retardation/developmental disabilities);

d. Is frequently physically aggressive or assaultive towards self or others;

e. Is a security risk, e.g., frequently runs or wanders away;

f. Is severely hyperactive, as diagnosed by a licensed doctor of medicine or osteopathy;

g. Demonstrates psychotic-like behavior as determined by the Consultive Committee.

Level of Care IMR-I requires that the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours.

II. Level of Care IMR II: Medicaid reimbursement for care and services at IMR-II level in an ICF/MR shall be limited to persons who are MR/DD as defined in this rule, and who are:

a. Moderately mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and;

b. For whom ICF/MR care is demonstrated to be the least restrictive environment appropriate to meet his/her needs.

Level of Care IMR-II requires that the applicant/recipient must require and receive a minimum of 2 hours of direct care and observation every 24 hours.

III. Level of Care of IMR-III: Medicaid reimbursement for care and services at IMR-III level in an ICF/MR shall be limited to persons who are MR/DD as defined in this rule, and who are:

a. Mildly mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and;

b. For whom ICF/MR care is demonstrated to be the least restrictive environment appropriate to meet his/her needs.

Level of Care IMR-III requires that the applicant/recipient must require and receive a minimum of 1 hour of direct care and observation every 24 hours.

Preadmission/Continued Stay Part A, Attachment A-1(g)

Limitations on Medicaid Reimbursement for Services Provided by an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

The following limitations are based upon the Governing Principles of Normalization, Least Restrictive Environment, Continuity, and Need.

Although an applicant/recipient may meet the necessary criteria, reimbursement will be denied for ICF/MR care if the Consultive Committee or its designees finds one or more of the following conditions applicable.

I. Except as provided for in paragraph III below, in accordance with the principle of Need, the applicant/recipient who meets all of the following criteria will be denied reimbursement for ICF/MR services if he or she is:

1. Moderately or mildly mentally retarded, without conditions qualifying him/her for Level-I care:

2. Ambulatory;

3. Continent;

4.. In need of less than weekly intervention by a licensed medical professional; and

5. Capable of daily attendance in day treatment or work settings, as determined by the Committee.

II. In accordance with the principles of Normalization, Least Restrictive Environment, and Continuity, the applicant/recipient must be referred for admission to the facility by a case manager of the Department of Social Services (DSS), or he/she will be denied Medicaid reimbursement.

1. Written documentation must be received with the request for reimbursement which demonstrates that ICF/MR is the least restrictive environment feasible for this resident, as demonstrated by DSS case management attempts to place the resident in less restrictive settings with no success.

2. This documentation must include the specific reasons why placement elsewhere was unsuccessful.

III. If, according to the principle of Least Restrictive Environment, the Consultive Committee finds that inadequate attempts have been made to utilize a less restrictive environment, the person will be denied reimbursement. All requests for ICF/MR Level-II and Level-III admission authorizations will be routinely reviewed by the Consultive Committee for adherence to the "least restrictive" principle. The Consultive Committee will scrutinize discharge plans for each individual to determine whether more appropriate community placements are utilized as available. For both preadmission and continued stay reviews, ICF/MR placement in these levels of care will be considered only as a substitute for more appropriate community placements when the more appropriate alternative is unavailable, and not as a primary resource for these individuals.

Preadmission/Continued Stay Part A, Attachment A-1(h)

Day Treatment

1. Day Treatment means the training and habilitation services for residents of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) which are delivered outside of the ICF/MR in programs currently licensed as a "Day Treatment Facility" by the State of Utah, Department of Social Services and which are:

a. Intended to aid the pre-vocational, self-help skill and/or self-sufficiency skill development of a qualified ICF/MR recipient;

b. Sufficient to meet the active treatment requirements of Title 42 Code of Federal Regulations, Sections 435.1009 and 442.463; and

c. Fully coordinated with and integrated with the active treatment program of the ICF/MR.

2. Upon the determination of the Bureau of Facility Review in order to ascertain client eligibility and compliance with program requirements, the Bureau of Facility Review may perform, but is not limited to, the following types of reviews:

a. Telephone review of the residents' services with ICF/MR and/or day treatment program; or

b. On-site review at either the day treatment program or the ICF/MR setting.

3. If a recipient is receiving day treatment at

defined above, the facility must have available for review documentation which supports that:

a. The resident is age 22 or older at the time of receipt of day treatment services;

b. The Interdisciplinary Team (IDT) of the ICF/MR determined that it is in the best interest of the recipient to receive training and habilitation in a licensed community day treatment program; and

c. The recipient has been determined by the Division of Rehabilitation Services, Utah State Office of Education, as not eligible for their services, i.e., not reasonably expected to be able to participate in a sheltered workshop, supported employment or in the general work force for one year.

4. To demonstrate that the day treatment service complies with the above requirements, additional documentation available for review must include:

a. A copy of the resident's established day treatment Individualized Program Plan (IPP). The IPP must:

(1) Indicate integration with the inpatient treatment plan being provided by the ICF/MR;

(2) Contain measurable objectives for the resident's acquisition of skills and desirable behaviors; the Individualized Program Plan may not solely address the reduction of maladaptive or undesirable behaviors;

(3) Specify time frames for accomplishment of objectives;

(4) Identify the day program staff who will be responsible for the implementation and review of the Individualized Program Plan;

(5) Be based on the Interdisciplinary Team findings from the ICF/MR's evaluation of the residents' care and service needs;

(6) Prescribe and direct the resident's participation in an integrated active treatment program of professionally developed and supervised training and therapies necessary for the individual to obtain the stated objectives;

(7) Prescribe a program of training and habilitation intended to aid the intellectual, sensorimotor, emotional and prevocational development of the resident;

(8) Indicate whether the resident is prepared to advance to more production-oriented level of training, sheltered, or competitive employment; and

(9) Identify the facility staff who will be responsible for monitoring the day treatment program.

5. Penalties for non-compliance can include, but are not limited to:

a. Inspection of Care deficiencies as a result of either a supplemental onsite review or other utilization review/control methods; and

b. Recovery of funds by the Division of Health Care Financing.

Bureau of Medical Review - Policy and Procedures Manual - Preadmission/Continued Stay - Part A ATTACHMENT A-1(2)

The Patient Assessment Section will utilize the following elements to determine that the applicant/recipient has mental or physical conditions which require services above the level of room and board and that can be provided only in an institution. the request for Medicaid approval must document that the applicant/recipient has two or more of the following elements:

1. The applicant/recipient requires total care and/or substantial physical assistance with ADL's, e.g., the applicant/recipient has a history of incontinence with previously documented diagnosis and failure to respond to treatment.

2. The attending physician has documented that the applicant/recipient's level of dysfunction in orientation to person, place and/or time requires institutional care.

3. The Consultive Committee will determine from submitted documentation (an evaluation and/or referral from protective services resulting from a current protective services intervention) that the applicant/recipient is a danger to him/her self and/or others.

4. The applicant/recipient has a diagnosis of mental retardation, but primarily requires medical management and services from an intermediate care facility rather than habilitation and training services from an intermediate care facility for the mentally retarded, as determined by the Consultive Committee.

In addition, before an applicant/recipient may be authorized for Medicaid coverage at the Intermediate II level of care, the following must take place:

a. Within thirty days prior to the request for Medicaid coverage, the applicant/recipient has had a physician complete a history and physical examination and the physician has certified that the applicant/recipient requires inpatient services at the intermediate level of care. The documentation correlates the diagnosis with objective physical findings, laboratory and x-ray data, plus medications and other treatments.

b. A comprehensive nursing assessment has been completed by a registered nurse. A licensed practical nurse may complete the assessment under the supervision of a registered nurse. The registered nurse must review, countersign and title any assessment completed by a licensed practical nurse.

c. A social services evaluation has been completed by appropriate qualified staff (MSW/CSW) and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart F. The social services evaluation may be completed by a SSW under supervision of an MSW/CSW. An assessment by a SSW is reviewed, countersigned and titled by the MSW/CSW consultant.

d. There is a written plan of care, directed by the attending physician, based upon the above requirements and conditions, which documents the frequency and intensity levels for all ADL's, established measurable outcomes for the applicant/recipient, and verifies that all identified needs will be met. The written plan of care contains all elements as defined in title 42 of Code of federal Regulations, Part 456, Section 456.380. The attending physician has signed the written plan of care.

e. As determined necessary and appropriate by the Consultive Committee, a psychological or psychiatric evaluation has been completed by appropriate qualified staff and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart F, in addition to the required medical and social evaluations.

f. There is a behavioral management plan for any applicant/recipient with a diagnosis that is coded within the ICD-9-CM's psychiatric code range (290.0 - 316). The behavioral management plan must follow the guidelines listed under "Behavioral Management" in this document.

g. There is adequate documentation of all previous less restrictive alternatives/services utilized to prevent or defer institutional care as specified on Page 1 of these criteria.

h. The applicant/recipient must require and receive a minimum of 2.0 hours of direct care and observation every 24 hours. A minimum of 20% of

the 2.0 hours of care must be provided by licensed practical nurses and/or registered nurses.

NOTE: If the intensity of services needed meets the criteria for skilled care as defined in Attachment A-1(c) (State Rulemaking, UDH-HCF-85-17), the applicant/recipient must be placed in a facility that is certified as a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care. Intermediate-I level of care is appropriate in a licensed/certified intermediate care facility (ICF).

1988 26-1-5, 26-18-3

R455-10. Pharmacy Policy

R455-10-1.

R455-10-1.

It is the policy of the Department of Health, Division of Health Care Financing that all Federal and State regulations pertaining to the professional standards of the licensed pharmacist must be maintained. Violation will result in imposed sanctions in accordance with 42 Code of Federal Regulations (CFR).

Dispensing medications in excess of the practitioner's order is not a covered Medicaid service. If special circumstances warrant, written documentation must be provided and be available for review by the Division of Health Care Financing.

All refills on any prescriptions must be identified with date and initials of dispensing pharmacist documented on the back of the prescription.

Schedule II medications must be dispensed as written.

A new hand written prescription is required for each dispensing of Schedule II medications.

Limitations and prior approval requirements of the Pharmacy program are outlined in the Utah State Plan Attachments 3.1-A, and 3.1-B.

The Pharmacy Provider manual explains the program in detail.

1987 26-1-5

R455-11. Dental Services

R455-11-1. General Policy for Dental Services

R455-11-1. General Policy for Dental Services

2.110 Services

A. Dental services are a benefit for eligible Medicaid recipients when performed by a licensed dentist who is a certified provider under the Utah State Title XIX (Medicaid) program, provided they are medically necessary and are not excluded by the limitations of the program. The limitations of the dental program are identified under Section 2.300 of this manual.

B. Recipient eligibility is determined by the Medicaid I.D. Card, which must be presented to the provider at each service visit. Prior authorization received from Medicaid to perform a service does not relieve the provider from verifying eligibility on the date the service is performed. The provider should check the name, recipient I.D. number and eligibility for the current month when the Medicaid I.D. Card is presented.

C. Prior authorization is not required, except for those procedures identified in the Medicaid Dental Index. (See Section 7) Procedures requiring prior authorization must be submitted on a Dentist Invoice separate from procedures not requiring prior authorization.

2.120 Authorization

The provision of appropriate dental service is under the authority of the 42 CFR in the following sections:

140.100 Definition

440.120 Definition

442.457 Service in ICF/MR

442.458 Treatment in ICF/MR

447.341 Payment

2.130 Goal Purpose

The goal of the Medicaid Dental Program is to provide a scope of dental services which will meet the basic dental needs of all Medicaid recipients, within the financial constraints of the program.

2.140 Objectives

The objective of the Medicaid Dental Program is to provide dental services to Medicaid recipients, such that the effects of dental decay are prevented or arrested and the teeth are restored to satisfactory functions. This limited objective gives rise to limitations in the scope of services, found in Section 2.300 of this manual. The provider should direct treatment toward the provision of the following services within the limitations of the program:

A. Annual diagnostic and preventive services.

B. Timely restorative and endodontic services for the preservation of the teeth.

C. Appropriate oral surgery services for the maintenance of good oral health.

D. Denture services necessary for maintaining satisfactory masticatory function.

E. Emergency services for the treatment of dental pain, infection or traumatic injury.

2.210 Program Coverage Diagnostic

A. An annual complete oral examination is a covered benefit, but limited examinations pursuant to specific procedures, such as root canal therapy and emergency visits, are considered part of the treatment rendered and are not covered.

B. Radiographs needed for an annual examination are covered, however, no combination of radiographs will pay more than the fee for a panorex film.

C. Radiographs needed for the diagnosis of emergency conditions are covered, but treatment radiographs, such as length of tooth films or root-tip recovery films, are considered part of the treatment rendered and are not covered.

2.220 Preventive

A. An annual prophylaxis is a covered benefit. In cases where periodontal pockets and subgingival calculus are present, a full mouth periodontal scaling and root planing may be substituted for the annual prophylaxis.

B. Occlusal sealants are a covered benefit only on the permanent molars of children under age 15.

C. Topical application of fluoride is a covered benefit only for children under age 21 and is always included as part of a child's annual prophylaxis.

D. Space maintainers are a covered benefit requiring prior approval, but a therapeutic pulpotomy to maintain space is the treatment of choice whenever feasible.

2.230 Restorative

A. Amalgam restorations are a covered benefit.

B. Resin restorations are a covered benefit on anterior teeth only.

C. Stainless steel crowns are a covered benefit.

D. Processed resin or porcelain fused to metal

(i) section 1396r(e) of this title;

(ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care;

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases; and

(C) use a utilization and quality control peer review organization (under part B of subchapter XI of this chapter), an entity which meets the requirements of section 1320c-1 of this title, as determined by the Secretary, or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1396b(m) of this title, with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide—

(A) with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of *benefits in such facility, in accordance* with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent

(42) provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan;

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d(a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d(a)(4)(B) of this title,

(B) providing or arranging for the provision of such screening services in all cases where they are requested, and

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services;

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1396b(g)(6) of this title (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case *of skilled nursing facility services or inter*mediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1320b-7 of this title;

(47) at the option of the State, provide for making ambulatory prenatal care available to *pregnant women during a presumptive eligi*bility period in accordance with section 1396r-1 of this title;

(48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1396r-2 of this title;

(50) provide, in accordance with subsection (q) of this section, for a monthly personal needs allowance for certain institutionalized individuals and couples;

(51)(A) meet the requirements of section 1396r-5 of this title (relating to protection of community spouses), and (B) meet the requirement of section 1396p(c) of this title (relating to transfer of assets); and

(52) meet the requirements of section 1396r-6 of this title (relating to extension of eligibility for medical assistance).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1396b(i)(4) of this title shall not apply to a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State

controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(e) Transition costs of closures or conversions permitted

A State plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

(f) Limitation on Federal participation in medical assistance

(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133⅓ percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(ii)(IX), 1396a(a)(10)(A)(ii)(X), or 1396d(p)(1) of this title or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title,

at the time of the provision of the medical assistance giving rise to such expenditure.

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title or which is a qualified health maintenance organization (as defined in section 300e-9(d) of this title)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days

(whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1396a(a) of this title whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33⅓ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1396a(a)(44) of this title shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

(i) 60 days after the date of the initial certification,

(ii) 180 days after the date of the initial certification,

(iii) 12 months after the date of the initial certification,

ment, and Coverage, Health Care Financing Administration, Department of Health and Human Services, 6324 Security Blvd, Baltimore, Maryland 21207, phone (301) 594-6719
1987 26-1-5

R455-8. Chiropractors' Services.

R455-8-1

R455-8-1
Pursuant to Utah Code Annotated, Second Replacement, Volume 7A, 1983 "Pocket Supplement" Section 63-46-5 7, State agencies are required to review their rule-making at five year intervals This rule-making reaffirms the continuation of policy expressed in adopted rule MA-79-7 (Archives Accession Number 3206) Chiropractic Services are not a benefit under Medicaid This rule will therefore continue for another 5 year period unless repeal action is taken There is no fiscal impact anticipated as a result of this continuation of policy
1987 26-1-5

R455-9. Nursing Facility Preadmission/Continued Stay Review and Level of Care Criteria.

R455-9-1. Purpose.

A The purpose of the Preadmission and Continued Stay Review programs set forth herein is to enable the Division of Health Care Financing (hereafter "Division")

1 to identify, statewide, the medical need of Title XIX applicants/recipients who are patients/residents of nursing care facilities or desire to be admitted to nursing care facilities in order to provide the appropriate type of care and services for illness or disability,

2 to assure quality of life while safeguarding against over or underutilization of services and costs, and

3 to ensure that certification for placement and reimbursement of nursing care facility services or for a State institution for acute care is given prior to placement, and

4 to ensure that persons with mental retardation/related conditions and/or mental illness seeking admission to or continued stay in nursing facilities are assessed for their need for active treatment services specific to these diagnoses

B Approval by the Division for nursing care for a Medicaid applicant/recipient is given only after professional analysis of alternative resources and settings of care appropriate to the total needs of the patient have been evaluated Alternatives to nursing facility care may include, but are not necessarily limited to, the following community resources

1 family,
2 homemaking services,
3 diet and nutrition,
4 socialization,
5 recreation,
6 physical therapy,
7 speech rehabilitation,
8 transportation,
9 economic assistance,
10 legal assistance,
11 counseling,
12 mental health services,
13 social support services,
14 housing assistance,
15 handicapped services,
16 services provided when applicable under Titles III, IV, VI, XVIII, and XX

C The decision to deny or grant preadmission or continued stay is an exercise of professional judg-

ment, utilizing developed criteria applied by qualified professionals licensed in the healing arts.

D. The Division staff will be available during regular business hours to assist applicants/recipients and providers, either by telephone or personal appointment upon request, in complying with the requirements of this program. The nursing facility will make application for preadmission authorization by submitting a plan of care developed and approved by the attending physician and the director of nurses, in accordance with current physician orders and certified as deliverable by the facility administrator. The application when accepted and approved by the Patient Assessment Section will constitute an agreement for payment of care/services.

R455-9-2. Authority.

A. The authority for the evaluation of each applicant's or recipient's need for admission and continued stay in the Skilled Nursing Facility and Intermediate Nursing Facility is defined under Federal Regulation 42 CFR 456.271 Medicaid Agency Review of Need for Admission (SNF), 42 CFR 456.371 Exploration of Alternative Services (ICF), 42 CFR 456.372 Medicaid Agency Review of Need for Admission (ICF), 42 CFR 456.331 Continued Stay Review Required (SNF), 42 CFR 456.431 Continued Stay Review Required (ICF), and the Omnibus Budget Reconciliation Act of 1987 (PL 100-203). The Division, in order to meet the requirements of the above regulations, has assigned the authority to assess the medical and social need, evaluate the level of care and assure appropriate placement to meet the applicant's or recipient's medical need to the Patient Assessment Section (hereafter "Section"), Bureau of Facility Review.

B. The Section has developed policies, procedures and medical criteria that will insure each applicant or recipient is assessed prior to placement and/or reimbursement, and to determine the duration of stay based upon continued review. These actions will safeguard against unnecessary or inappropriate use of Medicaid services and/or payment, while assuring the quality of services.

C. Under waiver authority granted to the Division effective January 1, 1982, these policies and procedures are designed to meet the intent of and are in lieu of all waiverable utilization review requirements of 42 CFR Part 456, Subpart D, and meet the utilization review requirements of 42 CFR Part 456, Subparts E, F, and G. Medical Care Evaluation Studies required under 42 CFR 456.341 — 345 are covered under policies and procedures for Surveillance and Utilization Review/Medical Care Evaluation Studies in the Bureau of Facility Review, Policy and Procedures Manual, Part C.

D. These policies and procedures also specify how physician certification and recertification requirements will be met in accordance with 42 CFR 456.160, 42 CFR 456.260, and 42 CFR 456.360.

E. The provisions of the Preadmission and Continued Stay Programs shall be governed by the Social Security Act, the laws of the State of Utah, under authority as granted by regulation as set forth in the 42 Code of Federal Regulation and Title XIX State Plan with which the Division ensures compliance.

R455-9-3. Availability.

A. Preadmission Assessment Evaluation is required for recipients of Title XIX (Medicaid) and applicants for Title XIX (Medicaid) who are pending eligibility determination.

1. This includes any applicants or recipients already in a nursing facility who will be reclassified from a skilled care level funded by Medicare and/or Medicaid to Medicaid skilled or intermediate care.

2. Preadmission Assessment Evaluation is required for the following persons, if application for Title XIX (Medicaid) is anticipated within 90 days:

a. persons who are in a nursing facility and currently funded from other sources including, but not limited to, Medicare, Veterans Administration and private pay; and

b. persons who have been referred by the mental health center or have a civil commitment to the mental health system.

B. Failure by the provider to complete Preadmission requirements will result in noncoverage of nursing facility care retroactive to eligibility application.

C. The preadmission assessment is also available for any other individual who requests this service.

R455-9-4. Safeguarding of Client Information.

A. The use or dissemination of any information concerning an applicant/recipient for any purpose not directly connected with the administration of the Preadmission and Continued Stay Program is prohibited except on written consent of the applicant/recipient, his attorney, or his responsible parent or guardian. (42 CFR 431.115)

B. Providers are responsible to ensure that information on patients who are not applicants for, or recipients of, Medicaid is not released without permission of the patient or guardian. The Division shall make available a form for this purpose.

R455-9-5. Free Choice of Providers.

A. A recipient may request service from any certified nursing care facility provider subject to 42 CFR 431.51.

B. A recipient who believes that the recipient's freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to 42 CFR 431.200.

C. A recipient's participation in medical assistance does not preclude the recipient's rights to seek and pay for services not covered by Medicaid.

R455-9-6. General Policy.

A. The following policies apply to all Medicaid facilities and patients:

1. Physician Certification for inpatient services will be performed by a physician consultant for the Division. The state physician consultant will certify the patient's/resident's need for care/services based upon orders of the attending physician, the written plan of care, and state and federal level of care criteria as found in 42 CFR 405.127, 405.128, 405.128a and in R455-9-19.

B. Responsible Agencies

1. Authorization for placement or receiving an inter-facility transfer as related to SNF and ICF reimbursement for the Medicaid applicant/recipient, and IMR for the developmentally disabled/mentally retarded applicant/recipient, shall be the express authority of the Division. This does not preclude discharging patients/residents in accordance with certified discharge planning procedures.

2. Authorization for placement, transfer and discharge as related to the Utah State Hospital has been contracted with the State Division of Mental Health, Department of Social Services.

3. Authorization for conducting in nursing facilities (except ICFs/MR) the Preadmission Screening and Annual Resident Review (PASARR) as specified

in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Section 1919 (b) (3) (F), shall be the responsibility of the Department of Social Services, Division of Services to the Handicapped (for persons with mental retardation/related condition) and the Division of Mental Health (for those persons with mental illness) and is governed pursuant to a Memorandum of Understanding with the Department of Social Services

C The Division will maintain final authority for the determination of continuing care need and level of care for Title XIX patients/residents in nursing care facilities and in the Utah State Hospital

D The Division will ensure the initial and periodic comprehensive medical, social and psychological assessments by an interdisciplinary team of health professionals, and when it is determined to be appropriate, facilitate discharge planning The applicant/recipient may elect to remain in the facility without reimbursement

E Discharge Planning

1 The Weekly Consultive Committee will review each patient's/resident's discharge plan When the status of the patient/resident is changed, the Committee will ensure that the patient/resident has a planned program of post discharge care that takes his/her care/service needs into account

2 The Provider must designate a staff member for discharge planning The discharge plan shall be included on the Patient Care Transmittal-Form 10/A

3 When the Division initiates a discharge action, the Section social worker will contact the Provider and/or the Discharge Planning Designee to coordinate the implementation of the discharge plan to insure that post discharge needs are met

4 However, when Title XIX (Medicaid) reimbursement is available for the patient/resident at a different level of care within the same facility, the discharge plan may be reevaluated, but it is not required that the Section social worker contact the Provider or the Discharge Planning Designee as required above

F Telephone Contact for Immediate Placement

1 The Division will reimburse the nursing care facility for a patient/resident who has received immediate placement in that nursing care facility, without full assessment following telephone authorization to the nursing care facility by the Patient Assessment Section (Section) Reimbursement authorization by telephone is only effective for five working days unless the provider completes the patient care transmittal (Form 10/A) and mails it to the Section within the five working day period following admission "Working days" is defined as all days except weekends and legal holidays

2 For applicants/residents of nursing facilities (except ICFs/MR), results of the Identification (ID) Screening, as required by OBRA 1987, Section 1919 (e) (7), for mental retardation/related conditions and mental illness diagnoses, and the ID Screening document number, must be available when requesting telephone contact for immediate placement If there is a positive finding of mental retardation/related conditions and/or mental illness from the ID screening, the Preadmission Screening and Annual Resident Review (PASARR) Determination findings must be supplied through the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health

a) A copy of the ID Screening and if appropriate, the PASARR Determination must be submitted in accordance with R455-9-7

3 The provider is responsible and required to complete the contact with the Section The providers accept a patient/resident at their own risk and liability without obtaining preadmission approval by the Division

G Preadmission authorization will not be required for a hospital admission when the applicant/recipient returns to the original nursing care facility within less than three consecutive days (the actual day of discharge is not counted) of admission to the hospital However, if the condition of a patient/resident returning to intermediate care or intermediate care for the mentally retarded in less than three-consecutive days (the actual day of discharge is not counted) may require skilled care, the nursing care facility must make immediate telephone contact with the Section

H Patients/Residents who leave the nursing care facility more than two consecutive days against medical advice, or who fail to return within two consecutive days after an authorized leave of absence, will be considered discharged from the Medicaid nursing care program and must complete all preadmission requirements before admission or readmission into the program Providers are responsible to report all such instances

I Patients/residents who leave the nursing facility (except ICFs/MR) under G and H above, who are subject to the PASARR Determination process, must be reassessed under the PASARR Determination process prior to readmission

J Weekly Consultive Committee Meetings shall be held in order to process applications for which an individual health professional desires additional professional consultation The Consultive Committee is chaired by the physician consultant and is comprised of additional health professionals as needed Determinations made in the committee meetings shall be documented on the Committee Action Report Form

K Supplemental Onsite Review (SOR) will be performed by a health professional from the Division at the Division's discretion when a question of appropriateness of placement cannot be resolved by telephone or written documentation The Division will also complete a Supplemental Onsite Review on written or telephone request of the Medicaid patient/resident, guardian or provider in the case of an adverse action

L Continued Stay Review

1 The Division will provide at a minimum a 30, 90, and 180-day interim telephone review for determination of the need for continued nursing care and services For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completion during the calendar month in which it is due An alternate schedule of more frequent review may be established based upon the professional evaluation of the patient's/resident's medical need for services

2 Providers must make appropriate personnel and information reasonably accessible to the Division by telephone

M Changes in Patient Condition and/or Treatment Plan

1 Providers must make contact with the Division by telephone or in writing when the needs of a patient/resident change so as to possibly require discharge or a different level of care

2 For nursing facility applicants/residents (except ICFs/MR) subject to the PASARR Determination process, providers must make contact with the Division by telephone or in writing when there is a change in the status which could have an affect on the person's PASARR determination

3. The Provider is expected to inform the Division of additional pertinent facts related to the care/service needs, diagnosis, medications, treatments, plan of care, etc., that may not have been known previous to the determination of medical need for admission and/or continued stay by the Division.

N. For skilled care patients the following applies:

1. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission.

2. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and all orders are signed.

3. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with 405.1123(b). At no time may the alternate schedule exceed 60 days between visits.

4. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient:

a. in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid Agency of the change in schedule, including justification; and

b. the utilization review committee or the medical review team (see 405.1121(d)) promptly reevaluates the patient's need for monthly physician visits as well as his or her continued need for skilled nursing facility services (see 405.1137(d)) (42 CFR 405.1123(b)).

5. The notification to the State Medicaid agency must be in writing and signed by the attending physician.

O. For intermediate patients, the following applies:

1. The physician must see the resident whenever necessary but at least once every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision. (42 CFR 442.346(b)).

2. The State Medicaid agency shall also be notified in writing by the attending physician of the reason that the patient/resident does not require the 60-day physician visit.

P. Every applicant for admission to a Medicaid certified nursing care facility and the Utah State Hospital will be certified by a physician and, if appropriate, reviewed by a psychiatrist.

Q. The Division will refer any willful misrepresentation of information to the Bureau of Program Review and the Office of Program Integrity for investigation and appropriate action.

R. The Division will automatically approve any Form 10/A that is not acted upon within 30 calendar days of receipt by the Division.

S. The Division will provide orientation and inservice to all nursing care providers, hospitals, related health agencies and the public upon request regarding the Preadmission and Continued Stay Review Programs.

T. Payment Authorization by the Division:

1. The Division will approve no payment for care/services to any nursing care facility prior to the date of receipt by the Patient Assessment Section of a valid contact as defined in R455-9-7 and completion of;

a. the assessment evaluation of each applicant/recipient;

b. all physician certification requirements; and

c. an ID Screening, and if appropriate, a PASARR Determination (except ICFs/MR) completed prior to admission; and

d. approval by the Patient Assessment Section.

2. There will be no exceptions to this policy. This means that Medicaid will not make payment for any care/services provided before the requirements of the preadmission program, as stated above, have been met.

3. If the provider does not choose to follow this policy, the provider will assume all liability for all incurred expenses for the care and services of the patient/resident. The provider will not bill the patient/resident or other responsible party for care/service not reimbursed by Medicaid due to the provider's failure to follow policy and procedures.

U. The following principles shall be used to determine responsibility for payment for nursing facility services whenever payment is sought from Medicaid by any party:

1. If eligibility and preadmission requirements and criteria have been met, Medicaid coverage consistent with the State plan will be provided.

2. If a provider submits a form 10A to the Section and he receives a denial notice on that 10A, the provider can resubmit additional or addendum documentation up to 60 calendar days from the date of receipt of the 10A by the Patient Assessment Section, as defined in R455-9-7, as a valid contact. If a provider fails to submit additional or addendum documentation to meet the specific criteria for denied placement of the patient within the 60 calendar day time frame, it will be understood that this placement denial will not be rescinded and the provider waives any and all rights to Medicaid reimbursement on this admission. A noted exception would be for any Medicaid reimbursement authorization previously granted by an approved telephone contact as defined in R455-9-6, F and R455-9-9.

3. If a provider has accepted a patient/resident who elects not to apply for or seek Medicaid coverage and payment, and the provider can demonstrate that the patient/resident or other responsible person has received adequate notice of preadmission requirements by having had the patient/resident or other responsible person read and complete the "Notice To Nursing Care Facility Patients, Residents, Applicants, and Other Responsible Persons" prior to providing service, then the responsibility for payment shall be considered to rest with the person signing the "Notice" form. The provider should give a signed copy of the "Notice" to the responsible party at the time that admitting procedures are completed.

4. If a provider cannot demonstrate that adequate notice was given to a patient/resident or other responsible person of eligibility and preadmission requirements for Medicaid reimbursement, the responsibility for payment for care/services will not rest with the Medicaid program or the patient/resident, or other person not given adequate notice for any period in which the patient/resident met all eligibility requirement for Medicaid reimbursement and was in fact determined to be eligible for Medicaid services.

V. The provider is responsible and required to determine and certify the responsible party for reimbursement of care, and to notify the Division of any proposed change in reimbursement status. In order to meet the requirements of this policy, the Division shall make available a form for this purpose.

W. The Section will utilize professional consultants as necessary with expertise in medicine, psychiatry, psychology, physical therapy, social services, occupational therapy, recreational therapy and mental retardation.

X. The Section will refer medically noneligible or ineligible applicants/recipients to appropriate health related agencies when the professional assessment identifies such a need. Referrals may be made to other agencies and institutions serving or meeting needs associated with alcohol and drugs, crippled children, DD/MR, mental health, etc.

Y. The Section will utilize data to develop and improve services in the Department of Health to the provider, to the patient/resident, and the community through alternative resources.

Z. Patient Information:

1. The Section will assess the availability of alternative financial sources, such as veterans' benefits and voluntary family contributions, for each patient/resident and will apply for or solicit payment from each available source.

2. Patients, guardians and other persons responsible for placement in nursing facility care are required to provide information regarding the identity, and whereabouts of all living parents, siblings and/or children of the patient.

3. The providers must make available to the Division the information available in their files on the identity and whereabouts of all living parents, siblings and/or children of the patient.

AA. The Section will maintain records of all preadmission assessments, approvals, deferrals of action, referrals to other agencies, denials, changes in reimbursement status, follow-up reports and any other materials pertinent to the program up to a two-year period of time.

BB. The Section will monitor performance of Preadmission Program policies and procedures as performed by contract agencies and agencies with Memorandums of Understanding.

CC. The Section will make determinations via telephone daily from 8:00 a.m. — 5:00 p.m, except weekends and holidays. The Section Manager may make appropriate administrative adjustments to section processing requirements to cover emergencies occurring during uncovered times.

DD. The Form 10/A, a statement of patient condition, the ID Screening and the PASARR Determination (if appropriate) will constitute a transmittal from the provider to the Division of the care/services to be actually delivered to the applicant/recipient and subject to inspection of care review. Services given pursuant to a provider contract and Form 10/A must be documented to receive consideration during continued stay review, physician certification and physician recertification.

EE. Patients/residents identified for a change in level of care/service or identified for discharge shall continue reimbursement at the current level until 10-day advance written notice can be given prior to change in payment level.

FF. The applicant/recipient or patient/resident shall have the right of appeal of adverse decisions in accordance with the Utah Administrative Procedures Act (UAPA), Utah Code Ann. 63-46b-1 et seq.

GG. The provider may not appeal a preadmission or continued stay determination; but in accordance with Bureau of Facility Review, Policy and Procedures Manual may appeal a decision denying Medicaid reimbursement to the provider due to the failure of the provider to follow the procedures set forth in this program.

R455-9-7. Definition of Valid Contact.

A. A valid contact is defined as documentation re*ceived by a telephone interview, a personal interview,* written on the designated Patient Review form or other written referral which contains a minimum of the following information:

1. baseline demographic data:

a. name of applicant/recipient;

b. projected placement;

c. date of transfer and/or admission to the facility (SNF, ICF, IMR);

d. age of applicant/recipient in order to evaluate for Medicare eligibility;

e. Medicaid eligibility status.

2. Diagnosis:

a. a list of all established diagnoses;

b. date of surgical procedures that precipitate need for care and/or date of traumatic incident such as fractured hip, CVA, acute MI, etc.;

c. reason for acute care inpatient hospitalization within prior 90-day period, if applicable, and the care and services needed.

3. Medications and treatments currently ordered for client.

4. Medical and social history; summary of present medical, social and where appropriate, developmental findings.

5. The applicant's/recipient's current functional and mental status.

6. The rehabilitation potential and anticipated duration of stay.

7. Evaluation of alternative care resources and support services currently in use, previously used, and available through the community and family.

8. Name of the individual initiating the contact.

9. ID Screening for mental retardation/related conditions and/or mental illness (except ICFs/MR) completed prior to admission.

10. A PASARR determination, completed prior to admission, from the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health for applicants/residents with a positive finding for mental retardation/related condition and/or mental illness on the ID screening.

B. In order for a contact to be valid, it must be received and processed by a registered nurse, medical doctor or doctor of osteopathy authorized by the Bureau of Facility Review. No other person is authorized to receive or process the contact.

C. Final action on a valid contact can be deferred when it is determined that the care/services of an applicant/recipient is reimbursed by a third party payor and/or the applicant/recipient is not now eligible for Title XIX (Medicaid). The contact will be held on a pending status until:

1. the applicant/recipient has been approved for Title XIX (Medicaid) reimbursement when the contact will be approved as of the initial approval date if all criteria have been met;

2. the applicant/recipient has been denied (does not meet criteria);

3. the applicant/recipient does not pursue Title XIX (Medicaid) reimbursement within 120 days of initial contact.

4. the applicant/recipient has been referred to an alternative placement by the Section; or

5. the applicant/recipient is deceased.

R455-9-8. Definition of Invalid Contact.

An invalid contact is one that does not meet all the requirements of a valid contact as defined in the preceding section (i e insufficient information to make a determination) An opinion may be given by the professional staff, but a final determination of approval/denial is not made An example of an an invalid contact is when an interested person inquires about the program but does not make a valid contact at that time

R455-9-9. Procedures for Processing Preadmission Reviews, Initial Contact.

A The initial contact for authorization of nursing home care placement can be generated from two sources

1 a telephone and/or an in-person interview or,

2 the receipt of written documentation, e g , a Form 10/A, that meets the requirements of a valid contact

B Authorization may be granted by a registered nurse and/or Qualified Mental Retardation Professional (Q M R P) assigned to the Bureau of Facility Review for an immediate placement need based upon a telephone and/or an in-person contact for one of the following conditions

1 A hospital must discharge the applicant/recipient, or the applicant/recipient has utilized the full extent of acute care scope of benefits

2 The patient's/resident's level of care has been changed by a fiscal intermediary for Medicare and/or the Medicare benefit days have been terminated and there is a need for continuing services reimbursed under Title XIX (Medicaid)

3 Protective services in the Department of Social Services has placed or is requesting to place an applicant/recipient for care

4 A tragedy has occurred in the home (i e fire, flood), accompanied by injury to an applicant/recipient, or an accident leaves a dependent person in imminent danger and he/she requires immediate institutionalization

5 The sudden illness or death of a family member who has been providing care to the applicant/recipient

6 When a provider has terminated services either through an adverse certification action or closure of the facility, to assure a smooth transfer of patients/residents to an appropriate location to meet their medical and/or habilitation needs

7 When the patient/resident presents a clear danger to himself/herself, other patients/residents or property in the present placement

C The provider should verify that approval has been given for the immediate placement to the specified facility prior to the admission of the patient/resident The authorization for immediate placement will only be valid for a period not to exceed five working days The provider must submit the complete assessment document (Form 10/A) postmarked within the approved five working day time frame to assure that reimbursement will be made from the date of admission

D If the provider fails to submit the Form 10/A within the five working day authorized period, payment will be terminated after five working days and will not be reinstated until receipt of the Form 10/A, and only if all preadmission criteria and conditions are met

E The telephone/in-person contact form is then logged, numbered and held in suspense to be matched with the required Form 10/A When the provider submits the Form 10/A within the five day authorized time frame, the provider will be reimbursed from the initial contact approval date or date of admission, whichever is later

R455-9-10. Authorizations.

A All admissions and/or transfers to a nursing care facility (SNF, ICF or IMR) must be authorized prior to admission of the patient/resident Placement will only be authorized upon receipt of the Form 10/A, unless the placement meets the conditions of immediate placement need as defined in the preceding sec tion If the provider requests, a receipt will be given for the Form 10/A when hand delivered by a representative of the provider

B Authorization for admission is not transferable from one nursing care facility to another The patient/resident must be processed through the preadmission program prior to each admission to each nursing care facility

C Retroactive authorization will not be given (prior to receipt of Form 10/A) for any admission and/or transfer into a nursing care facility from the applicant's/recipient's home, another nursing care facility or other location

D All ID Screenings must be completed prior to admission In the case where the applicant/resident/recipient has had an ID Screening completed previously resulting in a negative finding for mental retardation/related conditions and/or mental illness, and there have been no changes affecting the previous ID Screening findings, a new ID Screening is not required

E All applicants/residents who are subject to the PASARR determination process must complete the PASARR determination prior to admission Authorization from the PASARR determination is not transferable from one admission/facility to another

R455-9-11. Processing.

A Upon receipt of the Form 10/A the document control analyst and/or the secretarial support staff will stamp the date of receipt on the form, enter document number and all applicable data from transmittal on computer When applicable, the document control analyst and/or the secretarial support staff will also enter data from telephone contacts on computer, which will match with the Form 10/A by social security number The Form 10/A is then referred to the Section's Registered Nurse and Physician (M D or D O) who will

1 assess the applicant's/recipient's medical need for admission against written criteria,

2 determine the level of care required to meet the applicant's/recipient's medical need, and

3 authorize admission to the appropriate facility following the completion of the social assessment

B It is also the responsibility of the Registered Nurse and the Physician to deny placement when the applicant's/recipient's need does not meet the medical criteria, placement is not appropriate to meet the needs of the applicant/recipient, or if the patient's/resident's identified needs can be met by an appropriate and less costly alternative

C The assessment process is completed by the registered nurse in consultation with the physician assigned to the Section and with review by the Section's social worker as determined appropriate Other health professionals are also consulted as appropriate to evaluate the applicant/recipient's need The final determination is signed by the physician and the registered nurse

D. Appropriate notice of decision will be mailed to the applicant/recipient, the attending physician, the provider, and when possible, the next of kin.

R455-9-12. Continued Stay Review.

A. After the initial certification and authorization for admission and level of care determination has been made, the patient/resident is monitored for continued stay.

B. The document analyst, with back up secretarial support, is responsible to maintain the continued stay update files. Each approved patient/resident is reviewed by the professional staff at a minimum of 30, 90, and 180-days. For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completed during the calendar month in which it is due. The registered nurse and/or physician may determine that an individual patient/resident will require a more frequent update due to the patient's/resident's condition and/or medical needs. They will notify the document control analyst of the alternate schedule for review, and she/he will adjust the call-up schedule accordingly.

C. Each week the document control analyst and/or the secretarial support staff will have the forms requiring update ready for review by the physician, the registered nurse and social worker. The registered nurse and/or social worker will telephone the facility and determine:

1. the progress that has been achieved toward goals;
2. if the care is appropriate or if additional services are needed;
3. other discharge indicators;
4. if there is a change in the level of care for each client; and
5. other pertinent data.

D. The registered nurse and social worker will review the findings of the telephone update with the physician to establish the need for continued placement and the level of care until the next assigned review date or discharge.

E. The patient's/resident's continued stay review is also integrated with the annual inspection of care review cycle. Each patient/resident identified during the review process as potentially not being cared for at an appropriate level or in an appropriate setting will be reassessed within 30 days by the Section to determine continued stay or evaluated for placement in an appropriate alternative.

F. The patient/resident may be referred to the Section's social worker for evaluation of social needs in relationship to the potential for admission or discharge. These patient/residents will be further monitored and certified for continued stay until discharge is completed or the patient's/resident's condition changes to indicate a continued need for services due to a medical need. Following the discharge of the patient, the social worker will complete a follow-up of the post discharge status.

G. The patient/resident, on completion of the 180-day review, will then be followed during the annual on-site inspection of care review cycle. However, the patient/resident may continue to be reviewed on a more frequent schedule as determined by the section to be necessary. Patients/residents identified during the annual inspection of care who are potential discharge candidates will be referred to the section for complete review and assessment by the Weekly Consultive Committee and the Section social worker for discharge to an appropriate alternative.

R455-9-13. Weekly Consultative Committee.

A. The Section will refer to the Committee:

1. all applications that appear questionable and/or borderline;
2. all denial actions;
3. all applications that may be referred to other agencies for evaluation of alternative placement; and
4. all applicants/recipients or patients/residents where it appears to be feasible to meet their medical/health and/or habilitation needs through alternative services.

B. The Committee will meet at least on a weekly basis. The Committee will be chaired by the physician consultant and will consist of registered nurses, social workers, other health professional and patient representatives as needed.

C. The determinations of the Committee will be recorded on the Committee action report and will be retained with the Section's records.

R455-9-14. Determination by Patient Assessment Section.

A. A determination of medical need and placement will be made within seven working days following receipt of a Form 10/A from a nursing care facility.

B. A determination of medical need and placement or deferral status must be completed and notification given to the appropriate individuals within 30 calendar days following receipt of the Patient Care Transmittal-Form 10/A.

C. The document control analyst and the secretarial support staff will maintain official files of all actions taken. The actions to be taken must be one of the following:

1. approval;
2. deferral;
3. denial; or
4. change in reimbursement status.

R455-9-15. Approval Action.

A. When the recipient/applicant is approved for service, the Form 10/A is processed for entry into the payment mechanism.

B. Establishing the Effective and Expiration Dates of Form 10/A:

1. The effective date and expiration date for the period of service is established by staff assigned to the Section in accordance with established written policies and procedures. The effective date will be the date of receipt of the Form 10/A or the initial approval date of the telephone/in-person contact approval.

2. The expiration date is determined by the patient's/resident's need for services to be provided as determined by the evaluation of medical need as applied to written criteria. The Division will notify the patient/resident of final determination of discontinuation of Medicaid reimbursement for nursing facility care/services.

C. The patient's/resident's level of care code and effective date are entered on the computer by staff assigned to the Section.

D. The document control analyst or the secretarial support staff copies the front page of the Form 10/A and distributes it to:

1. the provider; and
2. document control with the original transmittal sheet.

E. The review document and all attachments will be filed in the Form 10/A file for continued stay review by the Patient Assessment Unit.

R455-9-16. Deferral Action.

A. Final determination of approval of an applicant/recipient may be deferred for any one or more of the following reasons:

1. The applicant/recipient has been referred to an appropriate alternative setting by the professional staff;

2. The applicant/recipient has not been approved for Medicaid (Title XIX) eligibility for reimbursement by the field service office serving the area in which the applicant/recipient resides;

3. The applicant/recipient is currently being reimbursed by a third party payor.

B. At the time of deferral action the application will be put on inactive status. The application will be reactivated if a written or telephone request is received within 10 days following notice to the applicant/recipient of the deferral action.

C. After 10 days, the applicant/recipient may be required to supply the Division with current and/or additional documentation of medical status/need in order to reactivate the application for admission.

D. A hearing will not be granted for a deferral action. However, the applicant/recipient may request a final determination of acceptance or denial in lieu of continued deferral.

R455-9-17. Denial Action.

A. The Section will deny admission or continued stay to all applicants/recipients or patients/residents who do not meet the medical criteria for admission/continued stay in a nursing care facility, or if the applicant's/recipient's medical need can be met by other available community and family resources.

B. When an applicant/recipient or patient/resident has been denied, the Section will send written notification to the nursing care facility administrator, the attending physician, the applicant/recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-18. Change in Reimbursement Status of Patient/Resident.

The Section may determine that the medical needs of the patient/resident requires a different level of care/services than when the current or initial authorization was given. When this determination is made, the Section will send written notification to the nursing care facility administrator, the attending physician, the recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-19. Physician Certification/Recertification.

A. The physician consultant will certify the need for inpatient services at the time the determination is made of the patient's/resident's level of care. The physician consultant will recertify the patient's/resident's continued need for inpatient nursing facility care/services at the determined level of care at least every 60 days after certification.

B. All patients meeting preadmission and continued stay requirements shall be deemed certifiable to the approved level of care by the physician consultant. The review schedule for continued stay review and the physician consultant's participation in that process shall be sufficient basis for certification. The physician will recertify a list of all patients/residents to the level of care approved by the preadmission assessment using the following statement:

"I certify that inpatient services are necessary for the next 60 days and the plan of care has been reviewed and approved for this patient."

C. No additional documentation shall be required. This procedure is intended to meet all Federal certification and recertification requirements.

D. All certification records shall be maintained by the Division.

E. With the assumption of the certification and recertification requirements, the State has no intent to assume the practice of medicine or to supersede the care requirements of the attending physician. The patient's/resident's attending physician continues to have the responsibility to meet the patient's/resident's needs and to assess the progress the patient/resident has achieved on a regular basis.

F. Patients/residents who are out of the facility less than 72 hours are not considered as a discharge and do not require a subsequent new certification for admission to the facility.

R455-9-20. Provider Responsibilities of Notice to the State Medicaid Agency.

A. The provider is responsible to notify the Division of any change in the patient's/resident's condition or status, a determination by the attending physician of an alternate schedule for physician visits, and/or any other pertinent data affecting the patient's/resident's need for nursing facility care/services.

B. The provider may telephone the Patient Assessment Section for a change in the patient's/resident's condition and/or the need for care/services.

C. If the attending physician determines that the patient's/resident's needs can be met with an alternate schedule, the Provider must submit to the Section, the justification and/or reasons from the attending physician for the alternate schedule. This may be a copy of the attending physician's order or progress note.

R455-9-21. Preadmission/Continued Stay Review and Level of Care Criteria.

A. The attached criteria requires that the Patient Assessment Section receive and approve the specific level of care before any Medicaid coverage can be authorized. The authorization for care is based upon the applicant's/recipient's severity of illness, intensity of service needed, anticipated outcome, and setting for service.

B. The Patient Assessment Section will utilize the Preadmission/Continued Stay Inpatient Care Transmittal-Form 10/A as the prior authorization document. Completion of this form is contingent on information obtained from the certification of need for inpatient care, medical, psychological and social evaluations, exploration of alternative services and individual written plan of care, which are required before admission to the nursing care facility as specified in Title 42 of the Code of Federal Regulations Part 456, Subparts E and F.

C. The provider may submit copies of the comprehensive medical evaluation, nursing care assessment, social services evaluation and interdisciplinary plan of care in lieu of filling out the sections of the Form 10/A which document the medical review, nursing assessment and social services evaluation. The pro-

vider is required to submit the Preadmission/Continued Stay Inpatient Care Transmittal and the Patient/Resident Release of Information Form *with all required documentation whenever there is a* request for Medicaid reimbursement authorization.

D. The Patient Assessment Section may require additional documentation to complete the preadmission assessment process.

R455-9-22. Level of Care Definitions.

A. "Active Treatment" means training and habilitation services defined in Title 42 Code of Federal Regulations, Section 435.1009 and Section 483.440, which are intended to aid the individual in intellectual, sensorimotor, and emotional development. These regulations are hereby adopted by reference.

1. Active Treatment under this definition is applicable only to individuals with a diagnosis of mental retardation or developmental disability residing in ICFs/MR.

B. "Activities of Daily Living (ADLs)" means the care normally provided for oneself in a normal lifestyle. Also includes adaptation to the use of assistive devices and prostheses intended to provide the greatest degree of independent functioning. This definition also takes into account a person's own perception of what constitutes an adequate life-style.

C. "Applicant" means an individual who has filed an application for the purpose of obtaining eligibility for the Medicaid program.

1. "Recipient" means an individual who has been deemed, by authorized Medicaid personnel, to meet the eligibility requirements for Medicaid benefits.

D. "Appropriate Services" means those services directly related to the applicant's/recipient's identified needs given in a timely manner and in sufficient quantity and quality to improve or maintain the person's condition.

1. Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs. Also refer to definition for active treatment.

E. "Behavior Management" means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of reducing observable negative behaviors. All behavior management programs must:

1. incorporate processes and methodologies which are the "least restrictive alternatives" available for producing the desired outcomes;

2. be conducted only following identification (and if feasible, remediation) of environmental and social factors which are likely to be precipitating or reinforcing the inappropriate behavior;

3. incorporate a process for identifying and reinforcing a desirable replacement behavior;

4. behavior management programs provided in ICF/MRs must meet the requirements of Title 42 Code of Federal Regulations Section 442.441.

5. All behavior management programs must include the following elements:

a. behavior baseline profile, consisting of:

(1) client's name;

(2) specific description of the undesirable behavior exhibited;

(3) condition(s) existing prior to and at the time of the undesirable behavior;

(4) date, time, location of incident(s);

(5) individuals present during incident(s);

(6) interventions used;

(7) results of interventions;

(8) recommendations for future action.

b. behavior management plan, consisting of:

(1) client's name;

(2) objectives stated in terms of specific behaviors;

(3) date of inception of program;

(4) when program will be used;

(5) names, titles, signatures of the individuals responsible for conducting the program;

(6) data collection methods;

(7) methods and frequency of data review.

c. program data sheet, consisting of:

(1) client's name;

(2) objective identified;

(3) date, time, location of behavior;

(4) client response to specific steps in the behavior management plan;

(5) signature or initials of individual conducting the program.

F. "Comprehensive Evaluation — ICF" means a medical and social evaluation of each person's need for care in an intermediate care facility, completed by the facility's interdisciplinary team of health professionals.

1. Based upon diagnosis, signs and symptoms, a current psychiatric and/or psychological evaluation is also completed by an appropriate health professional.

2. Each evaluation must include:

a. diagnosis;

b. summary of present medical, social and, where appropriate, developmental findings;

c. medical and social family history;

d. mental and physical functional capacity;

e. prognoses;

f. kind(s) of service(s) needed;

g. evaluation, by a worker employed by the Department of Social Services, of the resources available in the home, family and community; and

h. evaluation, by a worker employed by the Department of Social Services, which recommends either:

(1) admission to an intermediate care facility; or

(2) continued care in the intermediate care facility for persons who apply for Medicaid while in the intermediate care facility.

3. An Identification (ID) Screening completed prior to admission (except ICFs/MR) as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7), (see Attachment A-2, effective January 1, 1989).

4. For persons with a positive response to the ID Screening, the Preadmission and Annual Resident Review (PASARR) completed prior to admission, must be included as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7), (see R455-9-38).

G. "Comprehensive Evaluation-SNF" means the facility's attending physician must make:

1. a medical evaluation of each applicant's or recipient's need for care in the SNF;

2. a plan of rehabilitation, where applicable; and

3. a psychiatric and a social evaluation of need for care for any applicant/recipient with a diagnosis of mental illness.

4. Each evaluation must include:

a. diagnosis;

b. summary of present medical, social and, where appropriate, developmental findings;

c. medical and social family history;

d. mental and physical functional capacity;

e. prognoses;

f. kind(s) of service(s) needed;

g. a recommendation by a physician concerning either:

(1) admission to skilled nursing care facility; or

(2) continued care in the skilled nursing care facility for persons who apply for Medicaid while in the skilled nursing care facility.

5. An Identification (ID) Screening completed prior to admission (except ICFs/MR) as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7).

6. For persons with a positive response to the ID Screening, the Preadmission and Annual Resident Review (PASARR) completed prior to admission, must be included as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7).

H. "Day Treatment" means training and habilitation services delivered outside the nursing facility which are:

1. intended to aid the vocational, pre-vocational and/or self-sufficiency skill development of a qualified recipient;

2. sufficient to meet the active treatment requirements of Title 42 Code of Federal Regulations, Section 435.1009 and Section 483.440 (for mentally retarded/related conditions) and the "Active Treatment for Individuals with Mental Illness" definition contained in R455-9-37 (A); and

3. fully coordinated with and integrated with the active treatment program of the nursing facility.

I. "Developmental Programming" means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching or maintaining behaviors. Developmental Programming is based upon the same principles as Behavior Management (see above). However, Developmental Programming specifically refers to teaching adaptive behavior skills to improve individual personal and social development.

J. "Discharge Plan" means a plan which must insure that the applicant/recipient has an individualized planned program of post-discharge continuing care.

1. The discharge plan must:

a. state the medical, functional, behavioral, and social levels necessary for the applicant/recipient to be discharged to a less restrictive setting;

b. include steps needed to move applicant/recipient to a less restrictive setting;

c. establish the feasibility of the patient achieving the levels necessary for discharge; and

d. state the anticipated time frames for that achievement.

K. "Governing Principles" means the principles which govern Bureau determinations regarding eligibility for and provision of ICF/MR services, Medicaid reimbursement, hearings, and court actions. These principles include:

1. The developmental imperative: The natural impulse in all persons is toward growth and development, and will be expressed given the right kind of environmental stimulation. Therefore, MR/DD persons are capable of growth and development throughout their lives.

2. The active treatment imperative: In order to fulfill the MR/DD person's potential for growth and development, ICF/MR services must actively address identified treatment needs, not simply provide custodial care.

3. Normalization: ICFs/MR should provide the opportunity for life-styles which are set in the context of normal community life and which are as similar as possible to the typical cultural and community norms for the recipients' particular age group.

4. Integration: ICF/MR services should be integrated into the community, and should be no larger than that which the surrounding community can readily integrate into recreation, transportation, shopping, education, employment and socialization resources.

5. Separation: ICF/MR facilities should be primarily habilitative in nature, with other services such as education, work, medical treatment, and most recreational activities delivered out of home in regular community settings, as is the case for non-handicapped persons.

6. Specialization: ICF/MR facilities should specialize as much as possible according to similar resident needs. Thus, placement of divergent age groups or groups requiring distinctly different types of environments should be avoided.

7. Continuity: ICF/MR facilities should be part of a continuum of services, so that many options exist to meet the individual needs of the persons served.

8. Least Restrictive Environment: All persons have a basic right to live and work in the mainstream of society. Any separation from normal community life-styles in order to receive special services may be restrictive in several ways:

a. by causing society to view the person as different, deviant, or even undesirable;

b. by restricting opportunities for the person to learn and to interact freely with others;

c. by causing labeling and segregation which injures the person's chance to be self-supporting and integrated into the mainstream.

(1) Therefore, all persons should receive special services in settings which minimize separation from typical community life-styles. For the purposes of this rule, ICF/MR care is defined as more restrictive than that delivered in natural family homes, the person's own home, foster homes, board and care homes, and group homes.

9. Evaluation: Developmental testing for purposes of Medicaid reimbursement should be performed with recognized and standardized instruments that are appropriate to the person's age and level of functioning.

10. Training: Skills training and behavior modification used in ICF/MR settings should be delivered in a programming format which is based upon the principals of task analysis, appropriate reinforcement, consistency, and continuous assessment.

11. Need: In a system of limited resources, the most severely handicapped individuals should be given the highest priority for Medicaid services, in line with their greater treatment needs.

12. Purpose: The purpose of ICF/MR services is to provide a living situation which allows each person to maximize his/her ability to function as an accepted member of the community.

13. Rights: ICF/MR applicants/recipients are entitled to the same rights which are constitutionally afforded to all citizens.

L. "Mental Retardation/Developmental Disability (MR/DD)" means:

1. "Mental Retardation" means significantly subaverage intellectual functioning resulting in or associated with concurrent impairment(s) in adaptive behavior and manifest during the developmental period.

a. "Significantly subaverage intellectual functioning" means a score of two or more standard deviations below the mean on a standardized general intelligence test.

b "Developmental period" means the period of time between conception and the eighteenth birthday

2 "Developmental disability" means a severe, chronic disability that meets all of the following conditions

a is attributable to

(1) cerebral palsy, epilepsy, or

(2) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons

b is manifest before the person reaches age 22,

c is likely to continue indefinitely, and

d results in substantial functional impairments in three or more of the specified areas of major life activity (See Substantial Functional Impairment)

M "Plan of Care" means before admission to a Skilled Nursing Facility, or an Intermediate Care Facility (including ICF/MR), or before the effective date of authorization for payment for such services, the attending physician must establish a written plan of care for each applicant or recipient The plan of care must include

1 diagnoses, symptoms, complaints or complications indicating the need for admission,

2 a description of the functional level of the individual,

3 measurable objectives describing the desired future medical, functional and social status of the patient,

4 time frames for achieving objectives,

5 orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient,

6 plans for continuing care, including review and modification to the plan of care, and

7 plans for discharge (see "Discharge Plan"),

8 the attending or staff physician and other personnel involved in the person's plan of care, including the interdisciplinary team in an ICF, must review and update each plan of care at least every 60 days for skilled patients and at least every 90 days for intermediate patients

N "Substantial Functional Impairment" means demonstrable limitations which render the applicant/recipient incapable of reasonably performing three or more of the following major life activities

1 self-care,

2 understanding and use of language,

3 learning,

4 mobility,

5 self-direction, (e g , decision making, goal orientation, exercising civil rights, etc),

6 capacity for independent living

R455-9-23. Criteria for Intermediate Care.

A In accordance with Title 42 of the Code of Federal Regulations, Part 442, Section 251, the following requirements apply

1 An ICF must provide, on a regular basis, health-related care and services to individuals who do not require hospital or skilled care, but whose mental or physical condition requires services

a above the level of room and board, and

b that can be provided only by an institution

B Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs

C Authorization for Medicaid reimbursement at one of the Intermediate Care levels (ICF-I and II levels of care) is made only after review of Comprehensive Evaluation documentation which demonstrates that the applicant's/recipient's medical needs cannot be met, and the health status cannot be maintained, through the use of one or more of the following resources which are appropriate and available to the individual

1 outpatient physician services,

2 other outpatient medical services,

3 family,

4 volunteers,

5 chore services,

6 homemaking services,

7 diet and nutrition,

8 socialization,

9 recreation,

10 transportation,

11 economic assistance,

12 legal assistance,

13 counseling,

14 mental health services,

15 social support services,

16 housing assistance,

17 handicapped services,

18 services provided when applicable under Titles III, IV, VI, XVIII, and XX,

19 home and community based services,

20 home health,

21 personal care services,

22 other resources as appropriate and available

D NOTE If the intensity of services given or needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that meets the definition of a Skilled Care Facility The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care

R455-9-24. Criteria for Intermediate Care II.

A The Patient Assessment Section will utilize the following elements to determine that the applicant/recipient has mental or physical conditions which require services above the level of room and board and that can be provided only in an institution The request for Medicaid approval must document that the applicant/recipient has two or more of the following elements

1 Due to documented diagnosed medical conditions, the applicant/recipient requires total care and/or substantial physical assistance with activities of daily living Substantial physical assistance as defined in this policy means assistance above the level of verbal prompting (reminding), supervision, or set up

2 The Consultive Committee determines from submitted documentation that the attending physician has determined that the applicant/recipient's level of dysfunction in orientation to person, place and/or time requires institutional care

3 The Consultive Committee has determined from documentation submitted that the medical condition and intensity of services is such that the care needs of the patient cannot be safely met in a less structured setting There must be documentation that alternatives have been explored, utilized and why alternatives are not feasible

B. In addition, before an applicant/recipient may be authorized for Medicaid coverage at the Intermediate II level of care, the following must take place:

1. A physical examination shall be completed within 30 days before, or seven days after, admission. (NHR & REGS. Ch 5 5.102 PG 5.1).

2. A comprehensive nursing assessment has been completed by licensed nursing personnel.

3. A social services evaluation has been completed by appropriate qualified staff. Appropriate qualified staff is defined as a Social Service worker licensed as SSW or higher licensure and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart E.

4. Before admission or authorization for payment, a physician must establish a written plan of care which must include:

a. the need for admission;

b. a description of the functional level of the individual;

c. objectives and any orders for medications;

d. treatments;

e. restorative and rehabilitative services;

f. activities;

g. therapies;

h. social service;

i. diet and special procedures designed to meet the objective of the plan of care;

j. plans for continuing care, including review and modification of the care; and

k. plans for discharge (42 CFR 456.380).

5. As determined necessary and appropriate by the Consultive Committee, a psychological or psychiatric evaluation has been completed by appropriate qualified staff and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart F, in addition to the required medical and social evaluations.

6. Any applicant/recipient with a diagnosis that is coded within the ICD-9-CM's psychiatric code range (291.0 through 316.) must have documentation submitted indicating that an Interdisciplinary Team (IDT) has met to determine the need for a behavior management plan. If the IDT determines that a behavior management plan is necessary, a plan must be submitted that follows the guidelines listed under "Behavior Management" in the Department of Health, Nursing Care Facility Regulations and in this document. If the IDT determines that a behavior management plan is unnecessary, adequate documentation must be submitted to the Consultive Committee supporting the determination.

7. There is adequate documentation of all previous less restrictive alternatives/services utilized to prevent or defer institutional care as specified in these criteria.

8. The applicant/recipient must require and receive a minimum of 2.0 hours of direct care and observation every 24 hours. A minimum of 20% of the 2.0 hours of care must be provided by licensed practical nurses and/or registered nurses.

9. NOTE: If the intensity of services given or needed meets the criteria for skilled care as defined under this criteria, the applicant/recipient must be placed in a facility that is certified as a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

10. Continued Stay review will be conducted to:

a. Determine that the patient has shown significant improvement to enforce Discharge Planning.

b. Determine need for continued stay in a Long Term Care facility.

R455-9-25. Criteria for Intermediate Care I.

A. The applicant/recipient must meet all the criteria for intermediate care, and the required intensity of services needed must be less than that which meets the criteria for skilled care services.

B. The applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 25% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

C. In addition to meeting the criteria for intermediate care, the applicant/recipient must have documented service needs for one or more of the following:

1. Daily rehabilitative or restorative services provided under the direction of licensed professional staff, with documented measurable outcomes of treatment.

2. Close observation, documentation and follow-through to establish the impact of specified care services, which may include but are not limited to: services to patients with neurological involvement, hospice services, diabetes control, and dialysis; any of which may utilize laboratory services and physician intervention.

3. Documented training in personal care services to minimize dependency on staff for completion of activities for daily living.

4. Documented behavior management/modification program established because of specified aberrant behavior such as wandering, excessive sexual drive, destructive or aberrant acting out, prolonged depression leading to self-isolation or violent acts.

5. Specialized nursing services for skin and wound care, which does not qualify for skilled level of care.

6. Extensive interaction with professional staff to assist applicant/recipient and family through final stages of death and dying. Maximum allowable time is three months prior to the anticipated death.

7. Any skilled services listed under the skilled criteria, ordered and given more than two times each week but less frequently than required for skilled care.

8. NOTE: If the intensity of services needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that meets the definition of a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

R455-9-26. Criteria for Skilled Care II.

A. Skilled level of care means as duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.40(a). Skilled nursing facility services:

B. Skilled nursing facility for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases, means services that are:

1. needed on a daily basis and required to be provided on an inpatient basis as defined in Title 42 of the Code of Federal Regulations Part 409, Section 31 through Section 35.

2. provided by:

a. a facility or distinct part of a facility that is certified to meet the requirements for participation under Title 42 of the Code of Federal Regulations Part 442, Subpart C, as evidenced by a valid agreement

between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or

b. if specified in the State plan, a swing bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

3. ordered by and provided under the direction of a physician.

C. Skilled nursing facility services include services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Title 42 of the Code of Federal Regulations Part 405, Subpart K.

D. As duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.170(d): Skilled nursing facility services:

1. Skilled nursing facility services for individuals under 21 means those services specified in Title 42 of the Code of Federal Regulations, Part 440, Section 440.40 that are provided to recipients under 21 years of age.

2. In order to qualify for Medicaid skilled reimbursement, the applicant/recipient must have utilized the full scope of benefits for Medicare skilled nursing care or have been denied by Medicare for reasons other than the level of care requirements, i.e., the patient does not have a qualifying hospital stay in *order to restart the benefit period.*

3. In addition, the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 30% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

E. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.31: Level of care requirement, the following apply:

1. Definition: As used in this section, "skilled nursing and skilled rehabilitation services" means services that:

a. are ordered by a physician;

b. require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

c. are furnished directly by, or under the supervision of, such personnel.

F. Specific conditions for meeting level of care requirements:

1. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

2. Those services must be furnished for a condition:

a. for which the beneficiary received inpatient hospital services; or

b. which arose while the beneficiary was receiving care in a skilled or swing-bed hospital for a condition for which he or she received inpatient hospital services.

G. The daily skilled services must be ones that, as a practical matter, can only be provided in a skilled nursing facility, on an inpatient basis.

H. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.32: Criteria for skilled services and the need for skilled services, the following requirements apply:

1. The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

2. A condition that does not ordinaril skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled (such as those listed in 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

3. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in 409.33.

I. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.33: Examples of skilled nursing and rehabilitation services, the following requirements apply:

1. Services that could qualify as either skilled nursing or skilled rehabilitation services:

a. Overall management and evaluation of care *plan. The development, management, and evaluation* of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. This would include the management of a plan involving only a variety of personal care services when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. For example, an aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

b. Observation and assessment of the patient's changing condition. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and

evaluate the patient's need for modification of treatment for additional medical procedures until his or her condition is stabilized. For example, a patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) which serve as indicators for adjusting therapeutic measures. Likewise, surgical patients transferred from a hospital to a skilled nursing facility while in the complicated, unstabilized postoperative period, e.g., after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications, and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and/or the safety of others, i.e., to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders and/or nursing or therapy notes.

c. Patient education services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance. For example, a patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Likewise, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions, etc.

J. Services that qualify as skilled nursing services:

1. intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

2. levin tube and gastrostomy feedings;

3. nasopharyngeal and tracheostomy aspiration;

4. insertion and sterile irrigation and replacement of catheters;

5. application of dressings involving prescription medications and aseptic techniques;

6. treatment of extensive decubitus ulcers or other widespread skin disorder;

7. heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

8. initial phases of a regimen involving administration of medical gases;

9. rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

K. Services which would qualify as skilled rehabilitation services. NOTE: All services must comply with the requirements for direct supervision as defined in State Medicaid Plan.

1. Ongoing assessment of rehabilitation needs and potential — Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

2. Therapeutic exercises or activities — Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

3. Gait evaluation and training — Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

4. Range of motion exercises — Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

5. Maintenance therapy — Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning;

6. Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

7. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

8. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

L. Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in 42 CFR 409.32(b). Personal care services include, but are not limited to, the following:

1. administration of routine oral medications, eye drops, and ointments;

2. general maintenance care of colostomy and ileostomy;

3. routine services to maintain satisfactory functioning of indwelling bladder catheters;

4. changes of dressings for noninfected postoperative or chronic conditions;

5. prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

6. routine care of the incontinent patient, including use of diapers and protective sheets;

7. general maintenance care in connection with a plaster cast;

8. routine care in connection with braces and similar devices;

9. use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

10. routine administration of medical gases after a regimen of therapy has been established;

11. assistance in dressing, eating, and going to the toilet;

12. periodic turning and positioning in bed; and

13. general supervision of exercises which have been taught to the patient including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain

strength, or endurance, passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function, and assistive walking do not constitute skilled rehabilitation services

M In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409 34 Criteria for "daily basis", the following requirements apply

1 To meet the daily basis requirement specified in 42 CFR 409 31(b)(1), the following frequency is required

a skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week, or

b as an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week

2 A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue

N In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409 35 Criteria for "practical matter", the following requirements apply

1 General considerations — In making a "practical matter" determination, as required by 42 CFR 409 31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services However, in making that determination, the availability of Medicare and Medicaid payment for those services may not be a factor Example The beneficiary can obtain daily physical therapy from a Physical therapist in independent practice However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $100 of services furnished by such a practitioner in a year This limitation of payment may not be a basis for finding that the needed care can only be provided in a skilled nursing facility

2 Examples of circumstances that meet practical matter criteria

a Beneficiary's condition — Inpatient care would be required "as a practical matter" if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship

b Economy and efficiency — Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance

R455-9-27. Criteria for Skilled Care-I.

A The applicant/recipient must meet all the criteria for skilled care In addition, the applicant/recipient must meet all of the following conditions

1 The applicant/recipient must have utilized the full scope of benefits for skilled nursing care under Medicare or have been denied by Medicare for reasons other than the level of care requirements, i e , the patient does not have a qualifying hospital stay in order to restart the benefit period

2 The applicant/recipient must require and receive a minimum of 5.0 hours of direct care and observation every 24 hours

3 A minimum of 75% of the 5 0 hours of care must be provided by licensed practical nurses and/or registered nurses and shall include an aggregate of specialized care and services, patient instruction, etc , which can only be provided by licensed professionals

4 The attending physician has made the following determinations on which to base his written orders

a there is presently no reasonable expectation that the patient can any longer benefit from any care and services available in an acute care hospital that are not available in a skilled nursing care facility,

b the patient's condition requires physician follow-up at the skilled nursing care facility at a minimum of once every 30 days,

c a leave of absence from the nursing care facility is medically contraindicated due to the patient's medical condition, unless a leave is necessary for the patient to undergo medical tests at an inpatient hospital

5 The applicant's/recipient's needs for care, service, and supplies must meet all the following conditions both to qualify the applicant/recipient for Skilled Care-I and to qualify for Medicaid reimbursement at the Skilled Care-I level

a be ordered by a physician,

b be required, necessary and appropriate for specialized and complex care,

c each and every qualifying service must be verifiable based on adequate documentation in the applicant's/recipient's medical record

6 Except as otherwise provided, the applicant/recipient shall have been hospitalized immediately prior to admission to the skilled nursing care facility

7 The applicant/recipient must have been continuously approved for skilled level of care, either through Medicare or Medicaid, since admission to the skilled nursing facility

8 The attending physician's progress notes must be written and signed at the time of each physician visit and reflect the current medical status and condition of the patient

B The patient previously approved for Skilled Care-I payment and subsequently downgraded to a lesser level of payment may be returned to the Skilled Care-I category rather than being hospitalized in an acute care setting if

1 an exacerbation or complication occurs involving the applicant's/recipient's condition for which they were originally approved for Skilled Care-I,

2 the applicant/recipient meets all criteria contained in 1 through 8 above, except that there is no discharge from the hospital, and

3 it has been less than 30 days since the termination of the previous Skilled Care-I contract

C The following services are considered routine skilled care and services, and are excluded from the criteria for Skilled Care-I level

1 the skilled nursing services described in R455-9-26, 409 33(b),

2 the skilled rehabilitation services described in Attachment A-1(c), 409 33(c),

3 routine monitoring of medical gases after a regimen of therapy has been established,

4 routine levin tube and gastrostomy feedings, and

5 routine isolation room and techniques

R455-9-28. Limitations on Medicaid Reimbursement for Services Provided by a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF).

A Exclusions — Any applicant/recipient whose health, rehabilitative, and social needs may be rea-

sonably met through alternative non institutional services will be denied reimbursement for care in a skilled and intermediate care facility

B No applicant/recipient shall be approved for Medicaid reimbursement for skilled or intermediate level services if, as a practical matter, all his/her care and treatment needs can be met through alternative non-institutional services This exclusion does not apply if the cost of care through alternative non-institutional services is higher than the cost of care in an intermediate care facility

C Consideration will be given to the feasibility of using more economical alternative facilities and services in making this exclusion However, availability of Medicaid reimbursement for alternative services will not be a factor

1 Example — An applicant's/recipient's needs can all be met in a supervised residential setting or in a group home Medicaid reimbursement is not available for residential or group home placement This limitation on payment may not be a basis for finding that the needed care can only be provided in a skilled or intermediate care facility

D Limitations on Level of Care — Reimburseable levels of care are here ranked in order of intensity from the least intense to the most intense

1 Intermediate Care II,
2 Intermediate Care I,
3 Skilled Care-II,
4 Skilled Care-I

E No applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care

1 Example — An applicant/recipient has extremely fragile skin, but this problem has been appropriately managed with no occurrences of decubitus or skin tears in either an intermediate care facility or at the intermediate level of care in a SNF Reimbursement at the SNF level will not be approved

R455-9-29. Criteria for Approval of Medicaid Reimbursement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

A The purpose of the following criteria is two-fold First, to assure that the applicant/recipient meets the criteria for Levels of Care criteria as well as to verify qualifications to receive Medicaid reimbursement for ICF/MR services Second, to specify the services and outcomes which are required to qualify for the rate of reimbursement to ICF/MR residents for the three separate levels of ICF/MR care

B The three ICF/MR levels represent a range of severity of handicap and intensity of service needs which form the basis for active treatment Level IMR I represents the most severe level, and Level IMR-III represents the least severe level In accordance with the Governing Principle of Need, the highest rate of reimbursement will be paid for Level IMR-I care, and the lowest rate for Level IMR-III care

R455-9-30. Level of Care IMR-I.

A Medicaid reimbursement for care and services at IMR-I level in an ICF/MR is limited to persons who are MR/DD as defined in this rule and who have one or more of the following conditions

1 is severely or profoundly retarded,
2. is under six years of age,
3 is severely multiply handicapped (has two or more of the conditions specified in the definition of mental retardation/developmental disabilities),
4 is frequently physically aggressive or assaultive towards self or others,
5 is a security risk, e g , frequently runs or wanders away,
6 is severely hyperactive, as diagnosed by a licensed doctor of medicine or osteopathy,
7 Demonstrates psychotic-like behavior as determined by the Consultive Committee

B Level of Care IMR-I requires that the applicant/recipient must require and receive a minimum of 2 5 hours of direct care and observation every 24 hours

R455-9-31. Level of Care of IMR-II.

A Medicaid reimbursement for care and services at IMR-II level in an ICF/MR shall be limited to persons who are MR/DD as defined in this rule, and who are

1 moderately mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and,
2 the recipient would require the level of care provided in an ICF/MR in the absence of available Home and Community-Based Waiver services as demonstrated by a statement from the appropriate Office of Community Operations (OCO)

B Level of Care IMR-II requires that the applicant/recipient must require and receive a minimum of 2 hours of direct care and observation every 24 hours

R455-9-32. Level of Care of IMR-III.

A Medicaid reimbursement for care and services at IMR-III level in an ICF/MR shall be limited to persons who are MR/DD as defined in this rule, and who are

1 mildly mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and,
2 the recipient would require the level of care provided in an ICF/MR in the absence of available Home and Community Based Waiver services as demonstrated by a statement from the appropriate Office of Community Operations (OCO)

B Level of Care IMR III requires that the applicant/recipient must require and receive a minimum of 1 hour of direct care and observation every 24 hours

R455-9-33. Limitations on Medicaid Reimbursement for Services Provided by an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

A The following limitations are based upon the Governing Principles of "Normalization", "Least Restrictive Environment", Continuity, and "Need"

B Although an applicant/recipient may meet the necessary criteria, reimbursement will be denied for ICF/MR care if the Consultive Committee or its designees finds one or more of the following conditions applicable

1 Except as provided for in paragraph D below, in accordance with the principle of "Need", the applicant/recipient who meets all of the following criteria will be denied reimbursement for ICF/MR services if he or she is

1 moderately or mildly mentally retarded, without conditions qualifying him/her for Level-I care,
2 ambulatory,
3 continent,
4 in need of less than weekly intervention by a licensed medical professional, and

ADDENDUM B

State of Utah
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

Norman H Bangerter
Governor
Suzanne Dandoy, M D , M P H
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Rod Betit
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SOUTH DAVIS COMMUNITY HOSPITAL /Romero Petitioner,	)	
vs.	)	**FINAL AGENCY ACTION** Case No. 90-162-06
UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING, Respondent.	)	

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6151.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R410-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

ISSUE

WAS THE BUREAU OF MANAGED HEALTH CARE, DIVISION OF HEALTH CARE FINANCING CORRECT IN DENYING PAYMENT FOR DRG OUTLIER DAYS FOR SERVICES RENDERED BETWEEN AUGUST 8 AND OCTOBER 31, 1989?

FINDINGS OF FACT

The Findings of Fact entered by the presiding officer in Recommended Decision No. 90-162-06 are hereby incorporated by reference, with the exception of Finding of Fact No. 9. There was a discharge plan that was consistent with long term care.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the presiding officer in Recommended Decision No. 90-162-06 are hereby incorporated by reference.

DISPOSITION

WHEREFORE, upon review of the record as a whole, Recommended Decision No. 90-162-06 is hereby AFFIRMED.

REASONS FOR THE DISPOSITION

Section 1902(a)(30) of the Social Security Act provides that states must have methods and procedures to safeguard against unnecessary utilization of care and services. That Section states in pertinent part:

> A state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area [emphasis added].

Section 1903(g)(1) of the Social Security Act provides for penalties to states which do not make a satisfactory showing to the Secretary of Health and Human Services that it has an effective program of control over utilization of long-stay inpatient services. That Section of the Social Security Act is explained in 42 CFR 456.1(b) in pertinent part as follows:

> (b) The requirements in this part are based on the following sections of the Act...
>
> (2) Penalty for failure to have an effective program to control utilization of institutional services. Section 1903(g)(1) provides for a reduction in the amount of Federal Medicaid funds paid to a State for long-stay inpatient services if the State does not make a showing satisfactory to the Secretary that it has an effective program of control over utilization of those services. This penalty provision applies to inpatient services in hospitals, mental hospitals, skilled nursing facilities (SNF's), and intermediate care facilities (ICF's) [emphasis added].

These requirements are embodied in Utah Department of Health Administrative Rule R455-9 (currently numbered R414-9), entitled "Preadmission/Continued Stay Review and Level of Care Criteria," which states in pertinent part:

> No applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care.

In addition, Health and Human Services (HHS) can deny federal funding or FFP (federal financial participation) to states for failure to have specified utilization review procedures. Section 1903(i) provides that FFP is not available for expenditures for hospital or SNF services unless the institution has in effect a utilization review plan that meets Medicare requirements OR the Medicaid agency has a waiver from the Secretary of the Department of Health and Human Services demonstrating to his satisfaction that it has utilization review procedures superior in effectiveness to the Medicare procedures. That Section states:

> Payment under the preceding provisions of this section shall not be made---
>
> (4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

Since the Utah Medicaid Program has been granted a "superior systems waiver" by the Secretary of the Department of Health and Human services, the Utah Medicaid Program must follow the procedures and protocols implemented by the Bureau of Managed Health Care, Division of Health Care Financing, and approved by the Secretary of HHS. With regard to prepayment outlier review, the waiver states:

> Prepayment Outlier Review. Effective for discharges on or after July 1, 1988, hospitals must request outlier payment by submitting an outlier transmittal form and supporting documentation from the medical record of the admission with the claim for services. Supporting documentation is reviewed for appropriateness of continued stay, correctness of diagnoses and DRG assignment as determined by the provider, discharge planning, and appropriateness of transfers of patients between hospitals and to distinct part psychiatric and rehabilitation units. The reviewer completes the transmittal

> form by indicating the number of outlier days approved, and forwards it for payment. A copy of the completed form is returned to the provider. In addition, providers are notified in writing when payment for any days are not approved. The notice includes the number of days approved, if any, the number of days for which payment has been denied, and the reason(s) for denial of payment [see Utah State Department of Health (DOH) Hospital Utilization Review Superior Systems Waiver, Director's Exhibit No. 1 (emphasis added)].

In reviewing the South Davis Community Hospital's request for outlier days, the Bureau of Managed Health Care used criteria developed under its Superior Systems Waiver, referred to above. Respondent's Exhibit No. 6 is entitled "Override Option I, Appropriateness Evaluation Protocol" and contains the severity of illness and intensity of service criteria adopted by the Hospital Utilization Review Committee as authorized by the Department of Health's waiver. The respondent contended that the intensity of service provided to the patient and the severity of her illness did not justify keeping her in an acute care hospital setting between August 1 and October 31, 1989, although the medical necessity of the services rendered was not disputed. In other words, the respondent disputed the level of care for which the services rendered were being billed to Medicaid. The respondent contended that the same services could have been provided at a lesser level of care, namely, at the Skilled Nursing Facility (SNF) Level I, because the patient was in a chronic and stable state, although she was admittedly deteriorating. The respondent's witnesses testified that, based upon the medical documentation, there had been no change in the patient's chronic status for 22 months.

Respondent's counsel extensively questioned John C. Hylen, M.D., DOH physician consultant and member of the Utilization Review Committee, regarding whether the patient met the criteria for inpatient hospital care. Dr. Hylen testified that the patient did not meet the criteria. When asked why the patient did not meet criteria No. 7, "Intermittent or continuous respirator care at least every 8 hours," Dr. Hylen testified that, as a practical matter, that criterion refers to an individual who has been recently placed on a respirator--- "not someone who has been on a respirator for 22 months and is fairly stable." This testimony is consistent with the testimony of Respondent's witness, Katherine Dietrich, R.N., who testified that the patient has been on the respirator for a long period of time, it was nothing new for her, and that other patients on ventilators are able to be cared for at home. On cross examination, Petitioner's witness, Rosemary Lindsay, Assistant Administrator of South Davis Community Hospital, admitted there are ventilator-dependent patients who are cared for at the SNF level.

In further support of the respondent's contention that the patient could have been treated at the SNF level, Dr. Hylen testified that the documentation of the patient's condition by the doctors and nurses at the petitioner facility were not consistent with acute care hospitalization, but rather, nursing home services, because the treatment as documented in the medical records was basically the same for the three-month period in question.

Dr. Hylen testified that additional problems with the medical documentation were a lack of inpatient certification and recertification that is required by Section 1902(a)(44) of the Social Security Act. Section 1902(a)(44)(A) states:

> A state plan for medical assistance must---
>
> in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan---
>
> a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6)["at least every 60 days in the case of inpatient hospital services"] (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded every year), and accompanied by supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary, that such services are or were required to be given on an inpatient basis because the individual needs or needed such services...

The hearing officer allowed, over the respondent's objection, left the record open for the petitioner to submit additional medical evidence pertaining to the patient's condition and level of care during the period in question [see Petitioner's Exhibit No. 8]. However, such evidence does not meet utilization control requirements set forth in 42 CFR Part 456 which are based upon review of appropriate and timely medical documentation. Neither does the letter of C. Clark Welling, M.D., and David L. Scott, M.D. [see Petitioner's Exhibit No. 4] meet utilization control requirements or the requirements for keeping adequate and timely medical records. For example, 42 CFR 456.60 requires certification to be made at the time of inpatient hospitalization and recertification to be made at least every 60 days. Also, 42 CFR 482.24 pertains to the necessary contents of medical records and states in pertinent part:

> (2) All records must document the following, as appropriate:
> (viii) Final diagnosis with completion of medical records within 30 days following discharge [emphasis added].

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Accordingly, based upon the hearing record as a whole, the Bureau of Managed Health Care, Division of Health Care Financing was correct in not paying the petitioner, South Davis Community Hospital, for the outlier days during August through October 1989.

RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Final Agency Action is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Action.

A copy of this Final Agency Action shall be sent to Petitioner or representative at the last known address by certified mail, return receipt requested.

DATED this 23rd day of December 1992

BY: Rod Betit

Rod Betit
Interim Executive Director
UTAH DEPARTMENT OF HEALTH

ADDENDUM C

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

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SOUTH DAVIS COMMUNITY HOSPITAL /Romero, Petitioner,	:	
vs.	:	RECOMMENDED DECISION
UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING,	:	CASE NO. 90-162-06
Respondent.	:	

Pursuant to Rule R410-14 of the Utah Department of Health and the Utah Administrative Hearing Procedures Act, Section 63-46b-1 et seq., Utah Code Annotated, 1953 as amended, a formal administrative hearing for the above captioned case was held on the 30th day of July, 1990, at the Cannon Health Building located at 288 North 1460 West, Salt Lake City, Utah, at 10:00 A.M., Cornelius W. Hyzer, Hearing Officer, presiding. The petitioner ("South Davis") appeared by Gordon W. Bennett, and was represented by George K. Fadel, Attorney at Law. Also appearing on behalf of the petitioner were Rosemary Lindsay, Sahuna B. Cassel, and Lorree Carroll, R.N. The respondent was represented by Steve Mikita, Assistant Attorney General, and also appearing on behalf of the respondent were Martha Blaimer, Katherine M. Dietrich, Lois M. Combs and John C. Hylen, M.D. The hearing was concluded but the petitioner desired to review the case further and submit additional medical evidence in the form of a letter. Petitioner's Exhibit #8 was received on May 28, 1992. The respondent's expert was granted ten (10) days to review that exhibit and respond, but no response was ever received.

ISSUE

DID THE PETITIONER'S TREATMENT OF THE PATIENT, CATHERINE ROMERO, MEET THE REQUIREMENTS OF MEDICAID FOR REIMBURSEMENT FROM AUGUST 1, 1989, THROUGH OCTOBER 31, 1989?

Catherine Romero, age 29, developed a neurological disorder of unknown origin about the time she was nine years old. She was treated at Primary Children's Medical Center in 1983 and transferred to South Davis shortly thereafter (May 1983). She has resided at South Davis continuously since that time except for treatment for a respiratory arrest on September 7, 1987. She was placed in Lakeview Hospital for three (3) days and then discharged back to South Davis.

The petitioner, South Davis, was paid for the next 2 years by private insurance but when that policy was depleted, the guardian of Catherine Romero applied for Medicaid. This became effective August 1, 1989.

The Department of Health, Bureau of Managed Health Care, reviewed the request for payment for the period from August 1 through October 31, 1989, and informed South Davis of the decision on May 7, 1990. That letter, located in Respondent's Exhibit #11, pages 13-14, explained that the request of South Davis for reimbursement at the acute care hospital rate (7 days DRG plus 84 days Outlier) was denied because level of care did not meet the acute care criteria and the severity of illness and the intensity of services also did not meet the Medicaid criteria. Those criteria were reviewed in detail at the hearing by the respondent's expert medical witness. Also noted in the denial letter of May 7, 1990, was the lack of documentation concerning the Federally required certification and re-certification by a physician.

After the hearing, the petitioner's representatives requested additional time to submit rebuttal evidence on the severity of illness, intensity of services, and the need for acute care in a hospital setting. There were also extensive negotiations for settlement of this case, but all efforts failed, and on May 28, 1992, the petitioner submitted its last written exhibit.

FINDINGS OF FACT

1. The petitioner, South Davis Community Hospital, is a licensed Medicaid provider in the State of Utah, as a "Specialty Hospital" for "chronic disease," as set forth in Petitioner's Exhibit #1.

2. The petitioner accepted Catherine Romero as a patient in May 1983 for her chronic severe degenerative neuromuscular disease of unknown etiology.

3. The patient suffered a respiratory arrest on September 7, 1987, and was transferred to Lakeview Hospital for three (3) days after which she was re-admitted to South Davis for continuing treatment.

4. The record contains no physician certification for acute care and re-certification every 60 days as required by 42 CFR 456.60(a) and (b), as set forth in Respondent's Exhibit #7.

5. The patient received medical care necessary for her condition, including but not limited to: IV therapy, ventilator weaning trials, tracheostomy evaluation and care, seizure monitoring and gastrostomy tube feedings, during her 22 months at South Davis.

6. The patient was transferred to the skilled nursing level of care on November 1, 1989, after she was infection free for 45 days.

7. Medicaid approved the patient for a SNF I level of care reimbursement rate as of November 1, 1989, at the South Davis long term care facility.

8. The patient was seen by a physician 6 times in August, 5 times in September, and 4 times in October, as documented in the physician progress notes.

9. The record does not contain a "discharge plan" as required by Department of Health Rule R455-96-E, and set forth in Respondent's Exhibit #8, numbered page 5.

CONCLUSIONS OF LAW

1. The patient did not receive or require the level of care defined as "acute" from August 1, 1989, through October 31, 1989.

2. Medicaid correctly determined that the lack of physician certifications and re-certification applicable to the period from August 1, 1989, through October 31, 1989, precluded Medicaid from legally authorizing payment for services provided to the patient Catherine Romero.

REASONS FOR HEARING OFFICER'S DECISION

The petitioner had the burden to show that all requirements for payment were met. The primary requirement of the Code of Federal Regulations (CFR) is the certification and re-certification by a physician. The record contains no information about that basic requirement. It is obvious that re-certifications would be appropriate throughout the 22 months of acute hospital care but for the fact that private insurance covered it until August 1, 1989.

The fact that a private insurance carrier paid for acute care prior to August 1, 1989, is not probative. The primary issue before this court is whether the requirements of the CFR and the Department of Health rules were complied with. Besides the lack of physician certifications, the hearing developed a complete record of the services provided to the patient and the need for those services. This included a discussion of the specific criteria for admission to an acute care facility, as set forth in Respondent's Exhibit #6. That criteria is divided into part "A. SEVERITY OF ILLNESS" and part "B. INTENSITY OF SERVICE." Each part has multiple items listed of which only #7 of part "B" was admitted by the respondent's expert medical

witness as having been met. To be qualified under both part "A" and part "B", several items in each part must be "MET." The petitioner failed to document those criteria were met. The admitted criteria #B-7 states, "intermittent or continuous respirator care at least every 8 hours." The patient met this requirement but the respondent's expert medical witness testified that this service can be provided in a skilled nursing facility, such as South Davis, and in point of fact the patient is still at South Davis receiving skilled nursing care with continuous ventilator support (See Petitioner's Exhibit #4). The infrequency of doctor visits and/or the lack of a clear need for those visits as shown in the progress notes indicates a definite lack of acute care being provided. The activities of the nurses in providing the actual care for the patient was nothing beyond duties performed in the skilled nursing level of care, as testified to by the respondent's expert medical witness.

The petitioner provided the court with a letter dated July 18, 1990, signed by David L. Scott, M.D., which described the then present condition of the patient as:

1. Rancho Los Amigo Coma Level II with response only to painful stimuli,
2. Ventilator Dependent,
3. Gastrostomy Feedings,
4. Neurological dysfunction cognative [sic] in nature, without speech, social, motor function. She does not have cognative [sic] or social responses. (See Petitioner's Exhibit #4)

The letter details the condition of the patient approximately one year after the beginning of Medicaid coverage and shows that the condition of the patient is severe and treatable at the skilled nursing level at that time. Dr. Scott also states in that letter, that "obviously her course is one of downhill deterioration." In other words, Dr. Scott, the patient's own physician, appears to say that the condition of the patient is worse in July 1990 than it was in August 1989. There does not appear to be a significant improvement in the end of October 1989 which differentiates the change from "acute care" to the "skilled care" she is presently receiving. The petitioner's last exhibit submitted after the hearing did not provide significant new information. The letter did not focus on the level of care provided during the last three (3) months of treatment which the petitioner asserts was necessary at the "acute care" level through October 31, 1989. The information in that exhibit may accurately reflect the patient's needs during the initial period of time after her re-admission to South Davis on or about September 10, 1987, but not two (2) years later.

It should be re-emphasized that without a physician certification for the period from August 1 through October 31, 1989, no payment can ever be made by Medicaid for services rendered. This review included a discussion of the severity of illness and intensity of service issues for the purpose of providing a complete record for review.

RECOMMENDED AGENCY ACTION

The decision of Medicaid to deny payment of a 7 day DRG and 84 Outlier days for acute care services rendered to Catherine Romero from August 1, 1989, through October 31, 1989, is hereby AFFIRMED.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represent the results of that review, will be released simultaneously by the Department of Health, Division of Health Care Financing.

DATED this 8th day of December, 1992.

Cornelius W. Hyzer

CORNELIUS W. HYZER
HEARING OFFICER

ADDENDUM D

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) REQUIREMENTS FOR MENTAL ILLNESS (MI) OR MENTAL RETARDATION/RELATED CONDITIONS (MR)

BUREAU OF FACILITY REVIEW
PREADMISSION AND CONTINUED STAY REVIEW
POLICY AND PROCEDURES
JANUARY 3, 1989 RULEMAKING

R455 Health, Health Care Financing, Policy and Planning
R455-9 Nursing Facility Preadmission/Continued Stay Review and Level of Care Criteria
R455-9-1 Purpose

A. The purpose of the Preadmission and Continued Stay Review programs set forth herein is to enable the Division of Health Care Financing (hereafter "Division"):

1. to identify, statewide, the medical need of Title XIX applicants/recipients who are patients/residents of nursing care facilities or desire to be admitted to nursing care facilities in order to provide the appropriate type of care and services for illness or disability;

2. to assure quality of life while safeguarding against over or underutilization of services and costs; and

3. to ensure that certification for placement and reimbursement of nursing care facility services or for a State institution for acute care is given prior to placement; and

4. to ensure that persons with mental retardation/related conditions and/or mental illness seeking admission to or continued stay in nursing facilities are assessed for their need for active treatment services specific to these diagnoses.

B. Approval by the Division for nursing care for a Medicaid applicant/recipient is given only after professional analysis of alternative resources and settings of care appropriate to the total needs of the patient have been evaluated. Alternatives to nursing facility care may include, but are not necessarily limited to, the following community resources:

1. family;
2. homemaking services;
3. diet and nutrition;
4. socialization;
5. recreation;
6. physical therapy;
7. speech rehabilitation;
8. transportation;
9. economic assistance;
10. legal assistance;
11. counseling;
12. mental health services;
13. social support services;
14. housing assistance;
15. handicapped services;
16. services provided when applicable under Titles III, IV, VI, XVIII, and XX.

C. The decision to deny or grant preadmission or continued stay is an exercise of professional judgment, utilizing developed criteria applied by qualified professionals licensed in the healing arts.

D. The Division staff will be available during regular business hours to assist applicants/recipients and providers, either by telephone or personal appointment upon request, in complying with the requirements of this program. The nursing facility will make application for preadmission authorization by submitting a plan of care developed and approved by the attending physician and the director of nurses, in accordance with current physician orders and certified as deliverable by the facility administrator. The application when accepted and approved by the Patient Assessment Section will constitute an agreement for payment of care/services.

R455-9-2 Authority

A. The authority for the evaluation of each applicant's or recipient's need for admission and continued stay in the Skilled Nursing Facility and Intermediate Nursing Facility is defined under Federal Regulation 42 CFR 456.271 Medicaid Agency Review of Need for Admission (SNF), 42 CFR 456.371 Exploration of Alternative Services (ICF), 42 CFR 456.372 Medicaid Agency Review of Need for Admission (ICF), 42 CFR 456.331 Continued Stay Review Required (SNF), 42 CFR 456.431 Continued Stay Review Required (ICF), and the Omnibus Budget Reconciliation Act of 1987 (PL 100-203). The Division, in order to meet the requirements of the above regulations, has assigned the authority to assess the medical and social need, evaluate the level of care and assure appropriate placement to meet the applicant's or recipient's medical need to the Patient Assessment Section (hereafter "Section"), Bureau of Facility Review.

B. The Section has developed policies, procedures and medical criteria that will insure each applicant or recipient is assessed prior to placement and/or reimbursement, and to determine the duration of stay based upon continued review. These actions will safeguard against unnecessary or inappropriate use of Medicaid services and/or payment, while assuring the quality of services.

C. Under waiver authority granted to the Division effective January 1, 1982, these policies and procedures are designed to meet the intent of and are in lieu of all waiverable utilization review requirements of 42 CFR Part 456, Subpart D, and meet the utilization review requirements of 42 CFR Part 456, Subparts E, F, and G. Medical Care Evaluation Studies required under 42 CFR 456.341 - 345 are covered under policies and procedures for Surveillance and Utilization Review/Medical Care Evaluation Studies in the Bureau of Facility Review, Policy and Procedures Manual, Part C.

D. These policies and procedures also specify how physician certification and recertification requirements will be met in accordance with 42 CFR

E. The provisions of the Preadmission and Continued Stay Programs shall be governed by the Social Security Act, the laws of the State of Utah, under authority as granted by regulation as set forth in the 42 Code of Federal Regulation and Title XIX State Plan with which the Division ensures compliance.

R455-9-3 Availability

A Preadmission Assessment Evaluation is required for recipients of Title XIX (Medicaid) and applicants for Title XIX (Medicaid) who are pending eligibility determination.

1. This includes any applicants or recipients already in a nursing facility who will be reclassified from a skilled care level funded by Medicare and/or Medicaid to Medicaid skilled or intermediate care.

2. Preadmission Assessment Evaluation is required for the following persons, if application for Title XIX (Medicaid) is anticipated within 90 days:

persons who are in a nursing facility and currently funded from other sources including, but not limited to, Medicare, Veterans Administration and private pay; and

persons who have been referred by the mental health center have a civil commitment to the mental health system.

B. Failure by the provider to complete Preadmission requirements will result in noncoverage of nursing facility care retroactive to eligibility application.

C. The preadmission assessment is also available for any other individual who requests this service.

R455-9-4 Safeguarding of Client Information

A. The use or dissemination of any information concerning an applicant/recipient for any purpose not directly connected with the administration of the Preadmission and Continued Stay Program is prohibited except on written consent of the applicant/recipient, his attorney, or his responsible parent or guardian. 42 CFR 431.115)

B. Providers are responsible to ensure that information on patients who are not applicants for, or recipients of, Medicaid is not released without permission of the patient or guardian. The Division shall make available a form for this purpose.

R455-9-5 Free Choice of Providers

A. A recipient may request service from any certified nursing care facility provider subject to 42 CFR 431.51.

B. A recipient who believes that the recipient's freedom of choice of provider has been denied or impaired may request a fair hearing pursuant to 42 CFR 431.200.

C. A recipient's participation in medical assistance does not preclude the recipient's rights to seek and pay for services not covered by Medicaid.

R455-9-6 General Policy

A. The following policies apply to all Medicaid facilities and patients:

1. Physician Certification for inpatient services will be performed by a physician consultant for the Division. The state physician consultant will certify the patient's/resident's need for care/services based upon orders of the attending physician, the written plan of care, and state and federal level of care criteria as found in 42 CFR 405.127, 405.128, 405.128a and in R455-9-19.

B. Responsible Agencies

1. Authorization for placement or receiving an inter-facility transfer as related to SNF and ICF reimbursement for the Medicaid applicant/recipient, and IMR for the developmentally disabled/mentally retarded applicant/recipient, shall be the express authority of the Division. This does not preclude discharging patients/residents in accordance with certified discharge planning procedures.

2. Authorization for placement, transfer and discharge as related to the Utah State Hospital has been contracted with the State Division of Mental Health, Department of Social Services.

3. Authorization for conducting in nursing facilities (except ICFs/MR) the Preadmission Screening and Annual Resident Review (PASARR) as specified in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Section 1919 (b) (3) (F), shall be the responsibility of the Department of Social Services, Division of Services to the Handicapped (for persons with mental retardation/related condition) and the Division of Mental Health (for those persons with mental illness) and is governed pursuant to a Memorandum of Understanding with the Department of Social Services.

C. The Division will maintain final authority for the determination of continuing care need and level of care for Title XIX patients/residents in nursing care facilities and in the Utah State Hospital.

D. The Division will ensure the initial and periodic comprehensive medical, social and psychological assessments by an interdisciplinary team of health professionals, and when it is determined to be appropriate, facilitate discharge planning. The applicant/recipient may elect to remain in the facility without reimbursement.

E. Discharge Planning:

1. The Weekly Consultive Committee will review each patient's/resident's discharge plan. When the status of the patient/resident is changed, the Committee will ensure that the patient/resident has a planned program of post discharge care that takes his/her care/service needs into account.

2. The Provider must designate a staff member for discharge planning. The discharge plan shall be included on the Patient Care Transmittal-Form 10/A.

3. When the Division initiates a discharge action, the Section social worker will contact the Provider and/or the Discharge Planning Designee to coordinate the implementation of the discharge plan to insure that post discharge needs are met.

4. However, when Title XIX (Medicaid) reimbursement is available for the patient/resident at a different level of care within the same facility, the discharge plan may be reevaluated, but it is not required that the Section social worker contact the Provider or the Discharge Planning Designee as required above.

F. Telephone Contact for Immediate Placement:

1. The Division will reimburse the nursing care facility for a patient/resident who has received immediate placement in that nursing care facility, without full assessment following telephone authorization to the nursing care facility by the Patient Assessment Section (Section). Reimbursement authorization by telephone is only effective for five working days unless the provider completes the patient care transmittal (Form 10/A) and mails it to the Section within the five working day period following admission. "Working days" is defined as all days except weekends and legal holidays.

2. For applicants/residents of nursing facilities (except ICFs/MR), results of the Identification (ID) Screening, as required by OBRA 1987, Section 1919 (e) (7), for mental retardation/related conditions and mental illness diagnoses, and the ID Screening document number, must be available when requesting telephone contact for immediate placement. If there is a positive finding of mental

retardation/related conditions and/or mental illness from the ID screening, the Preadmission Screening and Annual Resident Review (PASARR) Determination findings must be supplied through the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health.

a.) A copy of the ID Screening and if appropriate, the PASARR Determination must be submitted in accordance with R455-9-7.

3. The provider is responsible and required to complete the contact with the Section. The providers accept a patient/resident at their own risk and liability without obtaining preadmission approval by the Division.

G. Preadmission authorization will not be required for a hospital admission when the applicant/recipient returns to the original nursing care facility within less than three consecutive days (the actual day of discharge is not counted) of admission to the hospital. However, if the condition of a patient/resident returning to intermediate care or intermediate care for the mentally retarded in less than three-consecutive days (the actual day of discharge is not counted) may require skilled care, the nursing care facility must make immediate telephone contact with the Section.

H. Patients/Residents who leave the nursing care facility more than two consecutive days against medical advice, or who fail to return within two consecutive days after an authorized leave of absence, will be considered discharged from the Medicaid nursing care program and must complete all preadmission requirements before admission or readmission into the program. Providers are responsible to report all such instances.

I. Patients/residents who leave the nursing facility (except ICFs/MR) under G and H above, who are subject to the PASARR Determination process, must be reassessed under the PASARR Determination process prior to readmission.

J. Weekly Consultive Committee Meetings shall be held in order to process applications for which an individual health professional desires additional professional consultation. The Consultive Committee is chaired by the physician consultant and is comprised of additional health professionals as needed. Determinations made in the committee meetings shall be documented on the Committee Action Report Form.

K. Supplemental Onsite Review (SOR) will be performed by a health professional from the Division at the Division's discretion when a question of appropriateness of placement cannot be resolved by telephone or written documentation. The Division will also complete a Supplemental Onsite Review on written or telephone request of the Medicaid patient/resident, guardian or provider in the case of an adverse action.

L. Continued Stay Review:

1. The Division will provide at a minimum a 30, 90, and 180-day interim telephone review for determination of the need for continued nursing care and services. For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completion during the calendar month in which it is due. An alternate schedule of more frequent review may be established based upon the professional evaluation of the patient's/resident's medical need for services.

2. Providers must make appropriate personnel and information reasonably accessible to the Division by telephone.

M. Changes in Patient Condition and/or Treatment Plan:

1. Providers must make contact with the Division by telephone or in writing when the needs of a patient/resident change so as to possibly require discharge or a different level of care.

2. For nursing facility applicants/residents (except ICFs/MR) subject to the PASARR Determination process, providers must make contact with the Division by telephone or in writing when there is a change in the status which could have an affect on the person's PASARR determination.

3. The Provider is expected to inform the Division of additional pertinent facts related to the care/service needs, diagnosis, medications, treatments, plan of care, etc., that may not have been known previous to the determination of medical need for admission and/or continued stay by the Division.

N. For skilled care patients the following applies:

1. The patient is seen by his attending physician at least once every 30 days for the first 90 days following admission.

2. The patient's total program of care (including medications and treatments) is reviewed during a visit by the attending physician at least once every 30 days for the first 90 days, and revised as necessary. A progress note is written and signed by the physician at the time of each visit, and all orders are signed.

3. Subsequent to the 90th day following admission, an alternate schedule for physician visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at 30-day intervals. This alternate schedule does not apply for patients who require specialized rehabilitative services, in which case the review must be in accordance with 405.1123(b). At no time may the alternate schedule exceed 60 days between visits.

4. If the physician decides upon an alternate schedule of visits of more than 30 days for a patient:

   a. in the case of a Medicaid benefits recipient, the facility notifies the State Medicaid Agency of the change in schedule, including justification; and

   b. the utilization review committee or the medical review team (see 405.1121(d)) promptly reevaluates the patient's need for monthly physician visits as well as his or her continued need for skilled nursing facility services (see 405.1137(d)) (42 CFR 405.1123(b)).

5. The notification to the State Medicaid agency must be in writing and signed by the attending physician.

O. For intermediate patients, the following applies:

1. The physician must see the resident whenever necessary but at least once every 60 days unless the physician decides that this frequency is unnecessary and records the reasons for that decision. (42 CFR 442.346(b)).

2. The State Medicaid agency shall also be notified in writing by the attending physician of the reason that the patient/resident does not require the 60-day physician visit.

P. Every applicant for admission to a Medicaid certified nursing care facility and the Utah State Hospital will be certified by a physician and, if appropriate, reviewed by a psychiatrist.

Q. The Division will refer any willful misrepresentation of information to the Bureau of Program Review and the Office of Program Integrity for investigation and appropriate action.

R. The Division will automatically approve any Form 1C/A that is not acted upon within 30 calendar days of receipt by the Division.

S. The Division will provide orientation and inservice to all nursing care providers, hospitals, related health agencies and the public upon request regarding the Preadmission and Continued Stay Review Programs.

T. Payment Authorization by the Division:

1. The Division will approve no payment for care/services to any nursing care facility prior to the date of receipt by the Patient Assessment Section of a valid contact as defined in R455-9-7 and completion of:

a. the assessment evaluation of each applicant/recipient;

b. all physician certification requirements; and

c. an ID Screening, and if appropriate, a PASARR Determination (except ICFs/MR) completed prior to admission; and

d. approval by the Patient Assessment Section.

2. There will be no exceptions to this policy. This means that Medicaid will not make payment for any care/services provided before the requirements of the preadmission program, as stated above, have been met.

3. If the provider does not choose to follow this policy, the provider will assume all liability for all incurred expenses for the care and services of the patient/resident. The provider will not bill the patient/resident or other responsible party for care/service not reimbursed by Medicaid due to the provider's failure to follow policy and procedures.

U. The following principles shall be used to determine responsibility for payment for nursing facility services whenever payment is sought from Medicaid by any party:

1. If eligibility and preadmission requirements and criteria have been met, Medicaid coverage consistent with the State plan will be provided.

2. If a provider submits a form 10A to the Section and he receives a denial notice on that 10A, the provider can resubmit additional or addendum documentation up to 60 calendar days from the date of receipt of the 10A by the Patient Assessment Section, as defined in R455-9-7, as a valid contact. If a provider fails to submit additional or addendum documentation to meet the specific criteria for denied placement of the patient within the 60 calendar day time frame, it will be understood that this placement denial will not be rescinded and the provider waives any and all rights to Medicaid reimbursement on this admission. A noted exception would be for any Medicaid reimbursement authorization previously granted by an approved telephone contact as defined in R455-9-6, F and R455-9-9.

3. If a provider has accepted a patient/resident who elects not to apply for or seek Medicaid coverage and payment, and the provider can demonstrate that the patient/resident or other responsible person has received adequate notice of preadmission requirements by having had the patient/resident or other responsible person read and complete the "Notice To Nursing Care Facility Patients, Residents, Applicants, and

Other Responsible Persons" prior to providing service, then the responsibility for payment shall be considered to rest with the person signing the "Notice" form. The provider should give a signed copy of the "Notice" to the responsible party at the time that admitting procedures are completed.

4. If a provider cannot demonstrate that adequate notice was given to a patient/resident or other responsible person of eligibility and preadmission requirements for Medicaid reimbursement, the responsibility for payment for care/services will not rest with the Medicaid program or the patient/resident, or other person not given adequate notice for any period in which the patient/resident met all eligibility requirement for Medicaid reimbursement and was in fact determined to be eligible for Medicaid services.

V. The provider is responsible and required to determine and certify the responsible party for reimbursement of care, and to notify the Division of any proposed change in reimbursement status. In order to meet the requirements of this policy, the Division shall make available a form for this purpose.

W. The Section will utilize professional consultants as necessary with expertise in medicine, psychiatry, psychology, physical therapy, social services, occupational therapy, recreational therapy and mental retardation.

X. The Section will refer medically noneligible or ineligible applicants/recipients to appropriate health related agencies when the professional assessment identifies such a need. Referrals may be made to other agencies and institutions serving or meeting needs associated with alcohol and drugs, crippled children, DD/MR, mental health, etc.

Y. The Section will utilize data to develop and improve services in the Department of Health to the provider, to the patient/resident, and the community through alternative resources.

Z. Patient Information:

1. The Section will assess the availability of alternative financial sources, such as veterans' benefits and voluntary family contributions, for each patient/resident and will apply for or solicit payment from each available source.

2. Patients, guardians and other persons responsible for placement in nursing facility care are required to provide information regarding the identity, and whereabouts of all living parents, siblings and/or children of the patient.

3. The providers must make available to the Division the information available in their files on the identity and whereabouts of all living parents, siblings and/or children of the patient.

AA. The Section will maintain records of all preadmission assessments, approvals, deferrals of action, referrals to other agencies, denials, changes in reimbursement status, follow-up reports and any other materials pertinent to the program up to a two-year period of time.

BB. The Section will monitor performance of Preadmission Program policies and procedures as performed by contract agencies and agencies with Memorandums of Understanding.

CC. The Section will make determinations via telephone daily from 8:00 a.m. - 5:00 p.m, except weekends and holidays. The Section Manager may make appropriate administrative adjustments to section processing requirements to cover emergencies occurring during uncovered times.

DD. The Form 10/A, a statement of patient condition, the ID Screening and the PASARR Determination (if appropriate) will constitute a transmittal from the provider to the Division of the care/services to be actually delivered to the applicant/recipient and subject to inspection of care review. Services given pursuant to a provider contract and Form 10/A must be documented to receive consideration during continued stay review, physician certification and physician recertification.

EE. Patients/residents identified for a change in level of care/service or identified for discharge shall continue reimbursement at the current level until 10-day advance written notice can be given prior to change in payment level.

FF. The applicant/recipient or patient/resident shall have the right of appeal of adverse decisions in accordance with the Utah Administrative Procedures Act (UAPA), Utah Code Ann. 63-46b-1 et seq.

GG. The provider may not appeal a preadmission or continued stay determination; but in accordance with Bureau of Facility Review, Policy and Procedures Manual may appeal a decision denying Medicaid reimbursement to the provider due to the failure of the provider to follow the procedures set forth in this program.

R455-9-7 Definition of Valid Contact

A. A valid contact is defined as documentation received by a telephone interview, a personal interview, written on the designated Patient Review form or other written referral which contains a minimum of the following information:

1. baseline demographic data:

   a. name of applicant/recipient;

   b. projected placement;

   c. date of transfer and/or admission to the facility (SNF, ICF, IMR);

   d. age of applicant/recipient in order to evaluate for Medicare eligibility;

   e. Medicaid eligibility status.

2. Diagnosis:

   a. a list of all established diagnoses;

   b. date of surgical procedures that precipitate need for care and/or date of traumatic incident such as fractured hip, CVA, acute MI, etc.;

   c. reason for acute care inpatient hospitalization within prior 90-day period, if applicable, and the care and services needed.

3. Medications and treatments currently ordered for client.

4. Medical and social history; summary of present medical, social and where appropriate, developmental findings.

5. The applicant's/recipient's current functional and mental status.

6. The rehabilitation potential and anticipated duration of stay.

7. Evaluation of alternative care resources and support services currently in use, previously used, and available through the community and family.

8. Name of the individual initiating the contact.

9. ID Screening for mental retardation/related conditions and/or mental illness (except ICFs/MR) completed prior to admission.

10. A PASARR determination, completed prior to admission, from the Department of Social Services, Divisions of Services to the Handicapped and/or Mental Health for applicants/residents with a positive finding for mental retardation/related condition and/or mental illness on the ID screening.

B. In order for a contact to be valid, it must be received and processed by a registered nurse, medical doctor or doctor of osteopathy authorized by the Bureau of Facility Review. No other person is authorized to receive or process the contact.

C. Final action on a valid contact can be deferred when it is determined that the care/services of an applicant/recipient is reimbursed by a third party payor and/or the applicant/recipient is not now eligible for Title XIX (Medicaid). The contact will be held on a pending status until:

1. the applicant/recipient has been approved for Title XIX (Medicaid) reimbursement when the contact will be approved as of the initial approval date if all criteria have been met;

2. the applicant/recipient has been denied (does not meet criteria);

3. the applicant/recipient does not pursue Title XIX (Medicaid) reimbursement within 120 days of initial contact.

4. the applicant/recipient has been referred to an alternative placement by the Section; or

5. the applicant/recipient is deceased.

R455-9-8 Definition of Invalid Contact

An invalid contact is one that does not meet all the requirements of a valid contact as defined in the preceding section (i.e. insufficient information to make a determination). An opinion may be given by the professional staff, but a final determination of approval/denial is not made. An example of an an invalid contact is when an interested person inquires about the program but does not make a valid contact at that time.

R455-9-9 Procedures for Processing Preadmission Reviews, Initial Contact

A. The initial contact for authorization of nursing home care placement can be generated from two sources:

1. a telephone and/or an in-person interview or;

2. the receipt of written documentation, e.g., a Form 10/A, that meets the requirements of a valid contact.

B. Authorization may be granted by a registered nurse and/or Qualified Mental Retardation Professional (Q.M.R.P.) assigned to the Bureau of Facility Review for an immediate placement need based upon a telephone and/or an in-person contact for one of the following conditions:

1. A hospital must discharge the applicant/recipient, or the applicant/recipient has utilized the full extent of acute care scope of benefits.

2. The patient's/resident's level of care has been changed by a fiscal intermediary for Medicare and/or the Medicare benefit days have been terminated and there is a need for continuing services reimbursed under Title XIX (Medicaid).

3. Protective services in the Department of Social Services has placed or is requesting to place a applicant/recipient for care.

4. A tragedy has occurred in the home (i.e. fire, flood), accompanied by injury to an applicant/recipient, or an accident leaves a dependent person in imminent danger and he/she requires immediate institutionalization.

5. The sudden illness or death of a family member who has been providing care to the applicant/recipient.

6. When a provider has terminated services either through an adverse certification action or closure of the facility, to assure a smooth transfer of patients/residents to an appropriate location to meet their medical and/or habilitation needs.

7. When the patient/resident presents a clear danger to himself/herself, other patients/residents or property in the present placement.

C. The provider should verify that approval has been given for the immediate placement to the specified facility prior to the admission of the patient/resident. The authorization for immediate placement will only be valid for a period not to exceed five working days. The provider must submit the complete assessment document (Form 10/A) postmarked within the approved five working day time frame to assure that reimbursement will be made from the date of admission.

D. If the provider fails to submit the Form 10/A within the five working day authorized period, payment will be terminated after five working days and will not be reinstated until receipt of the Form 10/A, and only if all preadmission criteria and conditions are met.

E. The telephone/in-person contact form is then logged, numbered and held in suspense to be matched with the required Form 10/A. When the provider submits the Form 10/A within the five day authorized time frame, the provider will be reimbursed from the initial contact approval date or date of admission, whichever is later.

R455-9-10 Authorizations

A. All admission and/or transfers to a nursing care facility (SNF, ICF or IMR) must be authorized prior to admission of the patient/resident. Placement will only be authorized upon receipt of the Form 10/A, unless the placement meets the conditions of immediate placement need as defined in the proceeding section. If the provider requests, a receipt will be given for the Form 10/A when hand delivered by a representative of the provider.

B. Authorization for admission is not transferable from one nursing care facility to another. The patient/resident must be processed through the preadmission program prior to each admission to each nursing care facility.

C. Retroactive authorization will not be given (prior to receipt of Form 10/A) for any admission and/or transfer into a nursing care facility from the applicant's/recipient's home, another nursing care facility or other location.

D. All ID Screenings must be completed prior to admission. In the case where the applicant/resident/recipient has had an ID Screening completed previously resulting in a negative finding for mental retardation/related conditions and/or mental illness, and there have been no changes affecting the previous ID Screening findings, a new ID Screening is not required.

E. All applicants/residents who are subject to the PASARR determination process must complete the PASARR determination prior to admission. Authorization from the PASARR determination is not transferable from one admission/facility to another.

R455-9-11 Processing

A. Upon receipt of the Form 10/A the document control analyst and/or the secretarial support staff will stamp the date of receipt on the form, enter document number and all applicable data from transmittal on computer. When applicable, the document control analyst and/or the secretarial support staff will also enter data from telephone contacts on computer, which will match with the Form 10/A by social security number. The Form 10/A is then referred to the Section's Registered Nurse and Physician (M.D. or D.O.) who will:

1. assess the applicant's/recipient's medical need for admission against written criteria;

2. determine the level of care required to meet the applicant's/recipient's medical need; and

3. authorize admission to the appropriate facility following the completion of the social assessment.

B. It is also the responsibility of the Registered Nurse and the Physician to deny placement when the applicant's/recipient's need does not meet the medical criteria, placement is not appropriate to meet the needs of the applicant/recipient, or if the patient's/resident's identified needs can be met by an appropriate and less costly alternative.

C. The assessment process is completed by the registered nurse in consultation with the physician assigned to the Section and with review by the Section's social worker as determined appropriate. Other health professionals are also consulted as appropriate to evaluate the applicant/recipient's need. The final determination is signed by the physician and the registered nurse.

D. Appropriate notice of decision will be mailed to the applicant/recipient, the attending physician, the provider, and when possible, the next of kin.

R455-9-12 Continued Stay Review

A. After the initial certification and authorization for admission and level of care determination has been made, the patient/resident is monitored for continued stay.

B. The document analyst, with back up secretarial support, is responsible to maintain the continued stay update files. Each approved patient/resident is reviewed by the professional staff at a minimum of 30, 90, and 180-days. For administrative purposes, the 30, 90, and 180-day review of continued stay will be defined as completion during the calendar month in which it is due. The registered nurse and/or physician may determine that an individual patient/resident will require a more frequent update due to the patient's/resident's condition and/or medical needs. They will notify the document control analyst of the alternate schedule for review, and she/he will adjust the call-up schedule accordingly.

C. Each week the document control analyst and/or the secretarial support staff will have the forms requiring update ready for review by the physician, the registered nurse and social worker. The registered nurse and/or social worker will telephone the facility and determine:

1. the progress that has been achieved toward goals;

2. if the care is appropriate or if additional services are needed;

3. other discharge indicators;

4. if there is a change in the level of care for each client; and

5. other pertinent data.

D. The registered nurse and social worker will review the findings of the telephone update with the physician to establish the need for continued placement and the level of care until the next assigned review date or discharge.

E. The patient's/resident's continued stay review is also integrated with the annual inspection of care review cycle. Each patient/resident identified during the review process as potentially not being cared for at an appropriate level or in an appropriate setting will be reassessed within 30 days by the Section to determine continued stay or evaluated for placement in an appropriate alternative.

F. The patient/resident may be referred to the Section's social worker for evaluation of social needs in relationship to the potential for admission or discharge. These patient/residents will be further monitored and certified for continued stay until discharge is completed or the patient's/resident's condition changes to indicate a continued need for services due to a medical need. Following the discharge of the patient, the social worker will complete a follow-up of the post discharge status.

G. The patient/resident, on completion of the 180-day review, will then be followed during the annual on-site inspection of care review cycle. However, the patient/resident may continue to be reviewed on a more frequent schedule as determined by the section to be necessary. Patients/residents identified during the annual inspection of care who are potential discharge candidates will be referred to the section for complete review and assessment by the Weekly Consultive Committee and the Section social worker for discharge to an appropriate alternative.

R455-9-13 Weekly Consultative Committee

A. The Section will refer to the Committee:

1. all applications that appear questionable and/or borderline;

2. all denial actions;

3. all applications that may be referred to other agencies for evaluation of alternative placement; and

4. all applicants/recipients or patients/residents where it appears to be feasible to meet their medical/health and/or habilitation needs through alternative services.

B. The Committee will meet at least on a weekly basis. The Committee will be chaired by the physician consultant and will consist of registered nurses, social workers, other health professional and patient representatives as needed.

C. The determinations of the Committee will be recorded on the Committee action report and will be retained with the Section's records.

R455-9-14 Determination by Patient Assessment Section

A. A determination of medical need and placement will be made within seven working days following receipt of a Form 10/A from a nursing care facility.

B. A determination of medical need and placement or deferral status must be completed and notification given to the appropriate individuals within 30 calendar days following receipt of the Patient Care Transmittal-Form 10/A.

C. The document control analyst and the secretarial support staff will maintain official files of all actions taken. The actions to be taken must be one of the following:

1. approval;

2. deferral;

3. denial; or

4. change in reimbursement status.

R455-9-15 Approval Action

A. When the recipient/applicant is approved for service, the Form 10/A is processed for entry into the payment mechanism.

B. Establishing the Effective and Expiration Dates of Form 10/A:

1. The effective date and expiration date for the period of service is established by staff assigned to the Section in accordance with established written policies and procedures. The effective date will be the date of receipt of the Form 10/A or the initial approval date of the telephone/in-person contact approval.

2. The expiration date is determined by the patients/resident's need for services to be provided as determined by the evaluation of medical need as applied to written criteria. The Division will notify the patient/resident of final determination of discontinuation of Medicaid reimbursement for nursing facility care/services.

C. The patient's/resident's level of care code and effective date are entered on the computer by staff assigned to the Section.

D. The document control analyst or the secretarial support staff copies the front page of the Form 10/A and distributes it to:

1. the provider; and

2. document control with the original transmittal sheet.

E. The review document and all attachments will be filed in the Form 10/A file for continued stay review by the Patient Assessment Unit.

R455-9-16 Deferral Action

A. Final determination of approval of an applicant/recipient may be deferred for any one or more of the following reasons:

1. The applicant/recipient has been referred to an appropriate alternative setting by the professional staff;

2. The applicant/recipient has not been approved for Medicaid (Title XIX) eligibility for reimbursement by the field service office serving the area in which the applicant/recipient resides;

3. The applicant/recipient is currently being reimbursed by a third party payor.

B. At the time of deferral action the application will be put on inactive status. The application will be reactivated if a written or telephone request is received within 10 days following notice to the applicant/recipient of the deferral action.

C. After 10 days, the applicant/recipient may be required to supply the Division with current and/or additional documentation of medical status/need in order to reactivate the application for admission.

D. A hearing will not be granted for a deferral action. However, the applicant/recipient may request a final determination of acceptance or denial in lieu of continued deferral.

R455-9-17 Denial Action:

A. The Section will deny admission or continued stay to all applicants/recipients or patients/residents who do not meet the medical criteria for admission/continued stay in a nursing care facility, or if the applicant's/recipient's medical need can be met by other available community and family resources.

B. When an applicant/recipient or patient/resident has been denied, the Section will send written notification to the nursing care facility administrator, the attending physician, the applicant/recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-18 Change in Reimbursement Status of Patient/Resident

The Section may determine that the medical needs of the patient/resident requires a different level of care/services than when the current or initial authorization was given. When this determination is made, the Section will send written notification to the nursing care facility administrator, the attending physician, the recipient, and if possible, the next of kin or sponsor in accordance with 42 CFR Part 431, Subpart D and Subpart E. Notice will be given no later than three working days after the decision is made, and for Medicaid patients, notice will be given at least 10 days in advance of the effective date of the action.

R455-9-19 Physician Certification/Recertification

A. The physician consultant will certify the need for inpatient services at the time the determination is made of the patient's/resident's level of care. The physician consultant will recertify the patient's/resident's continued need for inpatient nursing facility care/services at the determined level of care at least every 60 days after certification.

B. All patients meeting preadmission and continued stay requirements shall be deemed certifiable to the approved level of care by the physician consultant. The review schedule for continued stay review and the physician consultant's participation in that process shall be sufficient basis for certification. The physician will recertify a list of all patients/residents to the level of care approved by the preadmission assessment using the following statement:

> "I certify that inpatient services are necessary for the next 60 days and the plan of care has been reviewed and approved for this patient."

C. No additional documentation shall be required. This procedure is intended to meet all Federal certification and recertification requirements.

D. All certification records shall be maintained by the Division.

E. With the assumption of the certification and recertification requirements, the State has no intent to assume the practice of medicine or to supersede the care requirements of the attending physician. The patient's/resident's attending physician continues to have the responsibility to meet the patient's/resident's needs and to assess the

F. Patients/residents who are out of the facility less than 72 hours are not considered as a discharge and do not require a subsequent new certification for admission to the facility.

R455-9-20 Provider Responsibilities of Notice to the State Medicaid Agency

A. The provider is responsible to notify the Division of any change in the patient's/resident's condition or status, a determination by the attending physician of an alternate schedule for physician visits, and/or any other pertinent data affecting the patient's/resident's need for nursing facility care/services.

B. The provider may telephone the Patient Assessment Section for a change in the patient's/resident's condition and/or the need for care/services.

C. If the attending physician determines that the patient's/resident's needs can be met with an alternate schedule, the Provider must submit to the Section, the justification and/or reasons from the attending physician for the alternate schedule. This may be a copy of the attending physician's order or progress note.

PREADMISSION/CONTINUED STAY REVIEW
LEVEL OF CARE CRITERIA

R455-9-21 Preadmission/Continued Stay Review and Level of Care Criteria

A. The attached criteria requires that the Patient Assessment Section receive and approve the specific level of care before any Medicaid coverage can be authorized. The authorization for care is based upon the applicant's/recipient's severity of illness, intensity of service needed, anticipated outcome, and setting for service.

B. The Patient Assessment Section will utilize the Preadmission/Continued Stay Inpatient Care Transmittal-Form 10/A as the prior authorization document. Completion of this form is contingent on information obtained from the certification of need for inpatient care, medical, psychological and social evaluations, exploration of alternative services and individual written plan of care, which are required before admission to the nursing care facility as specified in Title 42 of the Code of Federal Regulations Part 456, Subparts E and F.

C. The provider may submit copies of the comprehensive medical evaluation, nursing care assessment, social services evaluation and interdisciplinary plan of care in lieu of filling out the sections of the Form 10/A which document the medical review, nursing assessment and social services evaluation. The provider is required to submit the Preadmission/Continued Stay Inpatient Care Transmittal and the Patient/Resident Release of Information Form with all required documentation whenever there is a request for Medicaid reimbursement authorization.

D. The Patient Assessment Section may require additional documentation to complete the preadmission assessment process.

R455-9-22 Level of Care Definitions

A. "Active Treatment" means training and habilitation services defined in Title 42 Code of Federal Regulations, Section 435.1009 and Section 483.440, which are intended to aid the individual in intellectual, sensorimotor, and emotional development. These regulations are hereby adopted by reference.

1. Active Treatment under this definition is applicable only to individuals with a diagnosis of mental retardation or developmental disability residing in ICFs/MR.

B. "Activities of Daily Living (ADLs)" means the care normally provided for oneself in a normal life-style. Also includes adaptation to the use of assistive devices and prostheses intended to provide the greatest degree of independent functioning. This definition also takes into account a person's own perception of what constitutes an adequate life-style.

C. "Applicant" means an individual who has filed an application for the purpose of obtaining eligibility for the Medicaid program.

1. "Recipient" means an individual who has been deemed, by authorized Medicaid personnel, to meet the eligibility requirements for Medicaid benefits.

D. "Appropriate Services" means those services directly related to the applicant's/recipient's identified needs given in a timely manner and in sufficient quantity and quality to improve or maintain the person's condition.

1. Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs. Also refer to definition for active treatment.

E. "Behavior Management" means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of reducing observable negative behaviors. All behavior management programs must:

1. incorporate processes and methodologies which are the "least restrictive alternatives" available for producing the desired outcomes;

2. be conducted only following identification (and if feasible, remediation) of environmental and social factors which are likely to be precipitating or reinforcing the inappropriate behavior;

3. incorporate a process for identifying and reinforcing a desirable replacement behavior;

4. behavior management programs provided in ICF/MRs must meet the requirements of Title 42 Code of Federal Regulations Section 442.441.

5. All behavior management programs must include the following elements:

a. behavior baseline profile, consisting of:

(1) client's name;

(2) specific description of the undesirable behavior exhibited;

(3) condition(s) existing prior to and at the time of the undesirable behavior;

(4) date, time, location of incident(s);

(5) individuals present during incident(s);

(6) interventions used;

(7) results of interventions;

(8) recommendations for future action.

b. behavior management plan, consisting of:

(1) client's name;

(2) objectives stated in terms of specific behaviors;

(3) date of inception of program;

(4) when program will be used;

(5) names, titles, signatures of the individuals responsible for conducting the program;

(6) data collection methods;

(7) methods and frequency of data review.

c. program data sheet, consisting of:

(1) client's name;

(2) objective identified;

(3) date, time, location of behavior;

(4) client response to specific steps in the behavior management plan;

(5) signature or initials of individual conducting the program.

F. "Comprehensive Evaluation--ICF" means a medical and social evaluation of each person's need for care in an intermediate care facility, completed by the facility's interdisciplinary team of health professionals.

1. Based upon diagnosis, signs and symptoms, a current psychiatric and/or psychological evaluation is also completed by an appropriate health professional.

2. Each evaluation must include:

   a. diagnosis;

   b. summary of present medical, social and, where appropriate, developmental findings;

   c. medical and social family history;

   d. mental and physical functional capacity;

   e. prognoses;

   f. kind(s) of service(s) needed;

   g. evaluation, by a worker employed by the Department of Social Services, of the resources available in the home, family and community; and

   h. An evaluation, by a worker employed by the Department of Social Services, which recommends either:

      (1) admission to an intermediate care facility; or

      (2) continued care in the intermediate care facility for persons who apply for Medicaid while in the intermediate care facility.

3. An Identification (ID) Screening completed prior to admission (except ICFs/MR) as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7), (see R455-9-38).

4. For persons with a positive response to the ID Screening, the Preadmission and Annual Resident Review (PASARR) completed prior to admission, must be included as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7), (see R455-9-38).

G. "Comprehensive Evaluation-SNF" means the facility's attending physician must make:

1. a medical evaluation of each applicant's or recipient's need for care in the SNF;

2. a plan of rehabilitation, where applicable; and

3. a psychiatric and a social evaluation of need for care for any applicant/recipient with a diagnosis of mental illness.

4. Each evaluation must include:

   a. diagnosis;

   b. summary of present medical, social and, where appropriate, developmental findings;

   c. medical and social family history;

   d. mental and physical functional capacity;

   e. prognoses;

   f. kind(s) of service(s) needed;

   g. a recommendation by a physician concerning either:

      (1) admission to skilled nursing care facility; or

      (2) continued care in the skilled nursing care facility for persons who apply for Medicaid while in the skilled nursing care facility.

5. An Identification (ID) Screening completed prior to admission (except ICFs/MR) as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7).

6. For persons with a positive response to the ID Screening, the Preadmission and Annual Resident Review (PASARR) completed prior to admission, must be included as required by the Omnibus Reconciliation Act (OBRA) of 1987, Section 1919 (e) (7).

H. "Day Treatment" means training and habilitation services delivered outside the nursing facility which are:

1. intended to aid the vocational, pre-vocational and/or self-sufficiency skill development of a qualified recipient;

2. sufficient to meet the active treatment requirements of Title 42 Code of Federal Regulations, Section 435.1009 and Section 483.440 (for mentally retarded/related conditions) and the "Active Treatment for Individuals with Mental Illness" definition contained in R455-9-37 (A); and

3. fully coordinated with and integrated with the active treatment program of the nursing facility.

I. "Developmental Programming" means the precisely planned, systematic application of the methods and experimental findings of behavioral science with the intent of altering observable behaviors, including increasing, decreasing, extending, restricting, teaching or maintaining behaviors. Developmental Programming is based upon the same principles as Behavior Management (see above). However, Developmental Programming specifically refers to teaching adaptive behavior skills to improve individual personal and social development.

J. "Discharge Plan" means a plan which must insure that the applicant/recipient has an individualized planned program of post-discharge continuing care.

1. The discharge plan must:

a. state the medical, functional, behavioral, and social levels necessary for the applicant/recipient to be discharged to a less restrictive setting;

b. include steps needed to move applicant/recipient to a less restrictive setting;

c. establish the feasibility of the patient achieving the levels necessary for discharge; and

d. state the anticipated time frames for that achievement.

K. "Governing Principles" means the principles which govern Bureau determinations regarding eligibility for and provision of ICF/MR services, Medicaid reimbursement, hearings, and court actions. These principles include:

1. The developmental imperative: The natural impulse in all persons is toward growth and development, and will be expressed given the right kind of environmental stimulation. Therefore, MR/DD persons are capable of growth and development throughout their lives.

2. The active treatment imperative: In order to fulfill the MR/DD person's potential for growth and development, ICF/MR services must actively address identified treatment needs, not simply provide custodial care.

3. Normalization: ICFs/MR should provide the opportunity for life-styles which are set in the context of normal community life and which are as similar as possible to the typical cultural and community norms for the recipients' particular age group.

4. Integration: ICF/MR services should be integrated into the community, and should be no larger than that which the surrounding community can readily integrate into recreation, transportation, shopping, education, employment and socialization resources.

5. Separation: ICF/MR facilities should be primarily habilitative in nature, with other services such as education, work, medical treatment, and most recreational activities delivered out of home in regular community settings, as is the case for non-handicapped persons.

6. Specialization: ICF/MR facilities should specialize as much as possible according to similar resident needs. Thus, placement of divergent age groups or groups requiring distinctly different types of environments should be avoided.

7. Continuity: ICF/MR facilities should be part of a continuum of services, so that many options exist to meet the individual needs of the persons served.

8. Least Restrictive Environment: All persons have a basic right to live and work in the mainstream of society. Any separation from normal community life-styles in order to receive special services may be restrictive in several ways:

   a. by causing society to view the person as different, deviant, or even undesirable;

   b. by restricting opportunities for the person to learn and to interact freely with others;

   c. by causing labeling and segregation which injures the person's chance to be self-supporting and integrated into the mainstream.

      (1) Therefore, all persons should receive special services in settings which minimize separation from typical community life-styles. For the purposes of this rule, ICF/MR care is defined as more restrictive than that delivered in natural family homes, the person's own home, foster homes, board and care homes, and group homes.

b. is manifest before the person reaches age 22;

c. is likely to continue indefinitely; and

d. Results in substantial functional impairments in three or more of the specified areas of major life activity (See Substantial Functional Impairment).

M. "Plan of Care" means before admission to a Skilled Nursing Facility, or an Intermediate Care Facility (including ICF/MR), or before the effective date of authorization for payment for such services, the attending physician must establish a written plan of care for each applicant or recipient. The plan of care must include:

1. diagnoses, symptoms, complaints or complications indicating the need for admission;

2. a description of the functional level of the individual;

3. measurable objectives describing the desired future medical, functional and social status of the patient;

4. time frames for achieving objectives;

5. orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

6. plans for continuing care, including review and modification to the plan of care; and

7. plans for discharge (see "Discharge Plan");

8. the attending or staff physician and other personnel involved in the person's plan of care, including the interdisciplinary team in an ICF, must review and update each plan of care at least every 60 days for skilled patients and at least every 90 days for intermediate patients.

N. "Substantial Functional Impairment" means demonstrable limitations which render the applicant/recipient incapable of reasonably performing three or more of the following major life activities:

1. self-care;
2. understanding and use of language;
3. learning;
4. mobility;
5. self-direction, (e.g., decision making, goal orientation, exercising civil rights, etc.);
6. capacity for independent living.

CRITERIA FOR INTERMEDIATE CARE

R455-9-23 Criteria for Intermediate Care

A. In accordance with Title 42 of the Code of Federal Regulations, Part 442, Section 251, the following requirements apply:

1. An ICF must provide, on a regular basis, health-related care and services to individuals who do not require hospital or skilled care, but whose mental or physical condition requires services:

   a. above the level of room and board; and

   b. that can be provided only by an institution.

B. Any intermediate or skilled nursing care facility must provide or arrange to provide all services necessary to meet each applicant's/recipient's identified needs.

C. Authorization for Medicaid coverage reimbursement at one of the Intermediate Care levels (ICF-I and II levels of care) is made only after review of Comprehensive Evaluation documentation which demonstrates that the applicant/recipient's medical needs cannot be met, and the health status cannot be maintained, through the use of one or more of the following resources which are appropriate and available to the individual:

1. outpatient physician servi.
2. other outpatient medical services;
3. family;
4. volunteers;
5. chore services;
6. homemaking services;
7. diet and nutrition;
8. socialization;
9. recreation;
10. transportation;
11. economic assistance;
12. legal assistance;
13. counseling;
14. mental health services;
15. social support services;
16. housing assistance;
17. handicapped services;
18. services provided when applicable under Titles III, IV, VI, XVIII, and XX;
19. home and community based services;
20. other resources as appropriate and available (home health);
21. personal care services;
22. other resources as appropriate and available.

D. NOTE: If the intensity of serivces given or needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that is certified as a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

CRITERIA FOR INTERMEDIATE CARE II LEVEL OF CARE

R455-9-24 Criteria for Intermediate Care II

A. The Patient Assessment Section will utilize the following elements to determine that the applicant/recipient has mental or physical conditions which require services above the level of room and board and that can be provided only in an institution. The request for Medicaid approval must document that the applicant/recipient has two or more of the following elements:

1. Due to documented diagnosed medical conditions, the applicant/recipient requires total care and/or substantial physical assistance with activities of daily living. Substantial physical assistance as defined in this policy means assistance above the level of: verbal prompting (reminding), supervision, or set up.

2. The Consultive Committee determines from submitted documentation that the attending physician has determined that the applicant/recipient's level of dysfunction in orientation to person, place and/or time requires institutional care.

3. The Consultive Committee has determined from documentation submitted that the medical condition and intensity of services is such that the care needs of the patient cannot be safely met in a less structured setting. There must be documentation that alternatives have been explored, utilized and why alternatives are not feasible.

B. In addition, before an applicant/recipient may be authorized for Medicaid coverage at the Intermediate II level of care, the following must take place:

1. A physical examination shall be completed within 30 days before, or seven days after, admission. (NHR & REGS. Ch 5 5.102 PG 5.1).

2. A comprehensive nursing assessment has been completed by licensed nursing personnel.

3. A social services evaluation has been completed by appropriate qualified staff. Appropriate qualified staff is defined as a Social Service worker licensed as SSW or higher licensure and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart E.

4. Before admission or authorization for payment, a physician must establish a written plan of care which must include:

   a. the need for admission;

b. a description of the functional level of the individual;

c. objectives and any orders for medications;

d. treatments;

e. restorative and rehabilitative services;

f. activities;

g. therapies;

h. social service;

i. diet and special procedures designed to meet the objective of the plan of care;

j. plans for continuing care, including review and modification of the care; and

k. plans for discharge (42 CFR 456.380).

5. As determined necessary and appropriate by the Consultive Committee, a psychological or psychiatric evaluation has been completed by appropriate qualified staff and meets the criteria in 42 Code of Federal Regulations, Part 456, Subpart F, in addition to the required medical and social evaluations.

6. Any applicant/recipient with a diagnosis that is coded within the ICD-9-CM's psychiatric code range (291.0 through 316.) must have documentation submitted indicating that an Interdisciplinary Team (IDT) has met to determine the need for a behavior management plan. If the IDT determines that a behavior management plan is necessary, a plan must be submitted that follows the guidelines listed under "Behavior Management" in the Department of Health, Nursing Care Facility Regulations and in this document. If the IDT determines that a behavior management plan is unnecessary, adequate documentation must be submitted to the Consultive Committee supporting the determination.

7. There is adequate documentation of all previous less restrictive alternatives/services utilized to prevent or defer institutional care as specified in these criteria.

8. The applicant/recipient must require and receive a minimum of 2.0 hours of direct care and observation every 24 hours. A minimum of 20% of the 2.0 hours of care must be provided by licensed practical nurses and/or registered nurses.

9. NOTE: If the intensity of services given or needed meets the criteria for skilled care as defined under this criteria, the applicant/recipient must be placed in a facility that is certified as a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

10. Continued Stay review will be conducted to:

    a. Determine that the patient has shown significant improvement to enforce Discharge Planning.

    b. Determine need for continued stay in a Long Term Care facility.

CRITERIA FOR INTERMEDIATE CARE I LEVEL OF CARE

R455-9-25 Criteria for Intermediate Care I

A. The applicant/recipient must meet all the criteria for intermediate care, and the required intensity of services needed must be less than that which meets the criteria for skilled care services.

B. The applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 25% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

C. In addition to meeting the criteria for intermediate care, the applicant/recipient must have documented service needs for one or more of the following:

1. Daily rehabilitative or restorative services provided under the direction of licensed professional staff, with documented measurable outcomes of treatment.

2. Close observation, documentation and follow-through to establish the impact of specified care services, which may include but are not limited to: services to patients with neurological involvement, hospice services, diabetes control, and dialysis; any of which may utilize laboratory services and physician intervention.

3. Documented training in personal care services to minimize dependency on staff for completion of activities for daily living.

4. Documented behavior management/modification program established because of specified aberrant behavior such as wandering, excessive sexual drive, destructive or aberrant acting out, prolonged depression leading to self-isolation or violent acts.

5. Specialized nursing services for skin and wound care, which does not qualify for skilled level of care.

6. Extensive interaction with professional staff to assist applicant/recipient and family through final stages of death and dying. Maximum allowable time is three months prior to the anticipated death.

7. Any skilled services listed under the skilled criteria, ordered and given more than two times each week but less frequently than required for skilled care.

8. NOTE: If the intensity of services needed meets the criteria for skilled care, the applicant/recipient must be placed in a facility that meets the definition of a Skilled Care Facility. The applicant/recipient will be denied Medicaid reimbursement for intermediate care if the intensity of service need meets the criteria for skilled care and the applicant/recipient is not located in a facility certified to provide the appropriate level of care.

CRITERIA FOR SKILLED II LEVEL OF CARE

R455-9-26 Criteria for Skilled Care II

A. Skilled level of care means as duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.40(a). Skilled nursing facility services:

B. Skilled nursing facility for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases, means services that are:

1. needed on a daily basis and required to be provided on an inpatient basis as defined in Title 42 of the Code of Federal Regulations Part 409, Section 31 through Section 35.

2. provided by:

a. a facility or distinct part of a facility that is certified to meet the requirements for participation under Title 42 of the Code of Federal Regulations Part 442, Subpart C, as evidenced by a valid agreement between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or

b. if specified in the State plan, a swing bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

3. ordered by and provided under the direction of a physician.

C. Skilled nursing facility services include services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Title 42 of the Code of Federal Regulations Part 405, Subpart K.

D. As duplicated and adopted in its entirety, the requirements found at Title 42 of the Code of Federal Regulations Part 440, Section 440.170(d): Skilled nursing facility services:

1. Skilled nursing facility services for individuals under 21 means those services specified in Title 42 of the Code of Federal Regulations, Part 440, Section 440.40 that are provided to recipients under 21 years of age.

2. In order to qualify for Medicaid skilled reimbursement, the applicant/recipient must have utilized the full scope of benefits for Medicare skilled nursing care or have been denied by Medicare for reasons other than the level of care requirements, i.e., the patient does not have a qualifying hospital stay in order to restart the benefit period.

3. In addition, the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours. A minimum of 30% of the 2.5 hours of care must be provided by licensed practical nurses and/or registered nurses.

E. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.31: Level of care requirement, the following apply:

1. Definition: As used in this section, "skilled nursing and skilled rehabilitation services" means services that:

a. are ordered by a physician;

b. require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

c. are furnished directly by, or under the supervision of, such personnel.

F. Specific conditions for meeting level of care requirements:

1. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

2. Those services must be furnished for a condition:

a. for which the beneficiary received inpatient hospital services; or

b. which arose while the beneficiary was receiving care in a skilled or swing-bed hospital for a condition for which he or she received inpatient hospital services.

G. The daily skilled services must be ones that, as a practical matter, can only be provided in a skilled nursing facility, on an inpatient basis.

H. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.32: Criteria for skilled services and the need for skilled services, the following requirements apply:

1. The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

2. A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled (such as those listed in 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

3. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in 409.33.

I. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.33: Examples of skilled nursing and rehabilitation services, the following requirements apply:

1. Services that could qualify as either skilled nursing or skilled rehabilitation services:

a. Overall management and evaluation of care plan. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. This would include the management of a plan involving only a variety of personal care services when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel. For example, an aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of

the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

b. Observation and assessment of the patient's changing condition. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment for additional medical procedures until his or her condition is stabilized. For example, a patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) which serve as indicators for adjusting therapeutic measures. Likewise, surgical patients transferred from a hospital to a skilled nursing facility while in the complicated, unstabilized postoperative period, e.g., after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications, and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, etc., may also require skilled observation and assessment by technical or professional personnel to assure their safety and/or the safety of others, i.e., to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders and/or nursing or therapy notes.

c. Patient education services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance. For example, a patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Likewise, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions, etc.

J. Services that qualify as skilled nursing services:

1. intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

2. levin tube and gastrostomy feedings;

3. nasopharyngeal and tracheostomy aspiration;

4. insertion and sterile irrigation and replacement of catheters;

5. application of dressings involving prescription medications and aseptic techniques;

6. treatment of extensive decubitus ulcers or other widespread skin disorder;

7. heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

8. initial phases of a regimen involving administration of medical gases;

9. rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs.

K. Services which would qualify as skilled rehabilitation services.

1. Ongoing assessment of rehabilitation needs and potential--Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

2. Therapeutic exercises or activities--Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

3. Gait evaluation and training--Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

4. Range of motion exercises--Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

5. Maintenance therapy--Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning;

6. Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

7. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

8. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

L. Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in 42 CFR 409.32(b). Personal care services include, but are not limited to, the following:

1. administration of routine oral medications, eye drops, and ointments;

2. general maintenance care of colostomy and ileostomy;

3. routine services to maintain satisfactory functioning of indwelling bladder catheters;

4. changes of dressings for noninfected postoperative or chronic conditions;

5. prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

6. routine care of the incontinent patient, including use of diapers and protective sheets;

7. general maintenance care in connection with a plaster cast;

8. routine care in connection with braces and similar devices;

9. use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

10. routine administration of medical gases after a regimen of therapy has been established;

11. assistance in dressing, eating, and going to the toilet;

12. periodic turning and positioning in bed; and

13. general supervision of exercises which have been taught to the patient including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

M. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.34: Criteria for "daily basis", the following requirements apply:

1. To meet the daily basis requirement specified in 42 CFR 409.31(b)(1), the following frequency is required:

   a. skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

b. as an exception, if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

2. A break of one or two days in the furnishing of rehabilitation services will not preclude coverage if discharge would not be practical for the one or two days during which, for instance, the physician has suspended the therapy sessions because the patient exhibited extreme fatigue.

N. In accordance with Title 42 of the Code of Federal Regulations, Part 409, Section 409.35: Criteria for "practical matter", the following requirements apply:

1. General considerations--In making a "practical matter' determination, as required by 42 CFR 409.31(b)(3), consideration must be given to the patient's condition and to the availability and feasibility of using more economical alternative facilities and services. However, in making that determination, the availability of Medicare and Medicaid payment for those services may not be a factor. Example: The beneficiary can obtain daily physical therapy from a Physical therapist in independent practice. However, Medicare pays only the appropriate portion (after deduction of applicable deductible and coinsurance amounts) of the first $100 of services furnished by such a practitioner in a year. This limitation of payment may not be a basis for finding that the needed care can only be provided in a skilled nursing facility.

2. Examples of circumstances that meet practical matter criteria:

a. Beneficiary's condition--Inpatient care would be required "as a practical matter" if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship.

b. Economy and efficiency--Even if the beneficiary's condition does not preclude transportation, inpatient care might be more efficient and less costly if, for instance, the only alternative is daily transportation by ambulance.

CRITERIA FOR SKILLED I LEVEL OF CARE

R455-9-27 Criteria for Skilled Care-I

A. The applicant/recipient must meet all the criteria for skilled care. In addition, the applicant/recipient must meet all of the following conditions:

1. The applicant/recipient must have utilized the full scope of benefits for skilled nursing care under Medicare or have been denied by Medicare for reasons other than the level of care requirements, i.e., the patient does not have a qualifying hospital stay in order to restart the benefit period.

2. The applicant/recipient must require and receive a minimum of 5.0 hours of direct care and observation every 24 hours.

3. A minimum of 75% of the 5.0 hours of care must be provided by licensed practical nurses and/or registered nurses and shall include an aggregate of specialized care and services, patient instruction, etc., which can only be provided by licensed professionals.

4. The attending physician has made the following determinations on which to base his written orders:

   a. there is presently no reasonable expectation that the patient can any longer benefit from any care and services available in an acute care hospital that are not available in a skilled nursing care facility;

   b. the patient's condition requires physician follow-up at the skilled nursing care facility at a minimum of once every 30 days;

   c. a leave of absence from the nursing care facility is medically contraindicated due to the patient's medical condition, unless a leave is necessary for the patient to undergo medical tests at an inpatient hospital.

5. The applicant's/recipient's needs for care, service, and supplies must meet all the following conditions both to qualify the applicant/recipient for Skilled Care-I and to qualify for Medicaid reimbursement at the Skilled Care-I level:

   a. be ordered by a physician;

   b. be required, necessary and appropriate for specialized and complex care;

c. each and every qualifying service must be verifiable based on adequate documentation in the applicant's/recipient's medical record.

6. Except as otherwise provided, the applicant/recipient shall have been hospitalized immediately prior to admission to the skilled nursing care facility.

7. The applicant/recipient must have been continuously approved for skilled level of care, either through Medicare or Medicaid, since admission to the skilled nursing facility.

8. The attending physician's progress notes must be written and signed at the time of each physician visit and reflect the current medical status and condition of the patient.

B. The patient previously approved for Skilled Care-I payment and subsequently downgraded to a lesser level of payment may be returned to the Skilled Care-I category rather than being hospitalized in an acute care setting if:

1. an exacerbation or complication occurs involving the applicant's/recipient's condition for which they were originally approved for Skilled Care-I;

2. the applicant/recipient meets all criteria contained in 1 through 8 above, except that there is no discharge from the hospital; and

3. it has been less than 30 days since the termination of the previous Skilled Care-I contract.

C. The following services are considered routine skilled care and services, and are excluded from the criteria for Skilled Care-I level:

1. the skilled nursing services described in R455-9-26, 409.33(b);

2. the skilled rehabilitation services described in Attachment A-1(c), 409.33(c);

3. routine monitoring of medical gases after a regimen of therapy has been established;

4. routine levin tube and gastrostomy feedings; and

5. routine isolation room and techniques.

LIMITATIONS ON MEDICAID REIMBURSEMENT FOR SKILLED (SNF) OR INTERMEDIATE (ICF) CARE FACILITIES

R455-9-28 Limitations on Medicaid Reimbursement for Services Provided by a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF)

A. Exclusions--Any applicant/recipient whose health, rehabilitative, and social needs may be reasonably met through alternative non-institutional services will be denied reimbursement for care in a skilled and intermediate care facility.

B. No applicant/recipient shall be approved for Medicaid reimbursement for skilled or intermediate level services if, as a practical matter, all his/her care and treatment needs can be met through alternative non-institutional services. This exclusion does not apply if the cost of care through alternative non-institutional services is higher than the cost of care in an intermediate care facility.

C. Consideration will be given to the feasibility of using more economical alternative facilities and services in making this exclusion. However, availability of Medicaid reimbursement for alternative services will not be a factor.

   1. Example--An applicant's/recipient's needs can all be met in a supervised residential setting or in a group home. Medicaid reimbursement is not available for residential or group home placement. This limitation on payment may not be a basis for finding that the needed care can only be provided in a skilled or intermediate care facility.

D. Limitations on Level of Care--Reimburseable levels of care are here ranked in order of intensity from the least intense to the most intense:

   1. Intermediate Care II;
   2. Intermediate Care I;
   3. Skilled Care-II;
   4. Skilled Care-I.

E. No applicant/recipient shall be approved for a more intense level of care if, as a practical matter, all his/her care and treatment needs can be met at a less intense level of care.

   1. Example--An applicant/recipient has extremely fragile skin, but this problem has been appropriately managed with no occurrences of decubitus or skin tears in either an intermediate care facility or at the intermediate level of care in a SNF. Reimbursement at the SNF level will not be approved.

CRITERIA FOR INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

R455-9-29 Criteria for Approval of Medicaid Reimbursement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)

A. The purpose of the following criteria is two-fold. First, to assure that the applicant/recipient meets the criteria for Levels of Care specified in this criteria as well as to verify qualifications to receive Medicaid reimbursement for ICF/MR services. Second, to specify the services and outcomes which are required to qualify for the rate of reimbursement to ICF/MR residents for the three separate levels of ICF/MR care.

B. The three ICF/MR levels represent a range of severity of handicap and intensity of service needs which form the basis for active treatment. Level IMR-I represents the most severe level, and Level IMR-III represents the least severe level. In accordance with the Governing Principle of Need, the highest rate of reimbursement will be paid for Level IMR-I care, and the lowest rate for Level IMR-III care.

R455-9-30 Level of Care IMR-I

A. Medicaid reimbursement for care and services at IMR-I level in an ICF/MR is limited to persons who are MR/DD and who have one or more of the following conditions:

1. is severely or profoundly retarded;

2. is under six years of age;

3. is severely multiply handicapped (has two or more of the conditions specified in the definition of mental retardation/developmental disabilities);

4. is frequently (more than once per week) physically aggressive or assaultive towards self or others;

5. is a security risk (runs or wanders away at least once per week);

6. is severely hyperactive, as diagnosed by a licensed doctor of medicine or osteopathy;

7. Demonstrates psychotic-like behavior as determined by the Consultive Committee.

B. Level of Care IMR-I requires that the applicant/recipient must require and receive a minimum of 2.5 hours of direct care and observation every 24 hours.

R455-9-31 Level of Care of IMR-II

A. Medicaid reimbursement for care and services at IMR-II level in an ICF/MR shall be limited to MR/DD persons who are:

1. moderately mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and;

2. the recipient would require the level of care provided in an ICF/MR in the absence of available Home and Community-Based Waiver services as demonstrated by a statement from the appropriate Office of Community Operations (OCO).

B. Level of Care IMR-II requires that the applicant/recipient must require and receive a minimum of 2 hours of direct care and observation every 24 hours.

R455-9-32 Level of Care of IMR-III

A. Medicaid reimbursement for care and services at IMR-III level in an ICF/MR shall be limited to MR/DD persons who are:

1. mildly mentally retarded and do not meet any of the other conditions to qualify for IMR-I level of reimbursement, and;

2. the recipient would require the level of care provided in an ICF/MR in the absence of available Home and Community-Based Waiver services as demonstrated by a statement from the appropriate Office of Community Operations (OCO).

B. Level of Care IMR-III requires that the applicant/recipient must require and receive a minimum of 1 hour of direct care and observation every 24 hours.

R455-9-33 Limitations on Medicaid Reimbursement for Services Provided by an Intrmediate Care Facility for the Mentally Retarded (ICF/MR)

A. The following limitations are based upon the Governing Principles of "Normalization", "Least Restrictive Environment" and "Need".

B. Although an applicant/recipient may meet the necessary criteria, reimbursement will be denied for ICF/MR care if the Consultive Committee or its designees finds one of the following conditions applicable:

1. Except as provided for in paragraph D below, in accordance with the principle of "Need", the applicant/recipient who meets all of the following criteria will be denied reimbursement for ICF/MR services if he or she is:

1. moderately or mildly mentally retarded, without conditions qualifying them for Level-I care;

2. ambulatory;

3. continent;

4. in need of less than weekly intervention by a licensed medical professional; and

5. capable of daily attendance in day treatment or work settings, as determined by the Committee.

C. In accordance with the principles of "Normalization" and "Least Restrictive Environment", the applicant/recipient must be referred for admission to the facility by a case manager of the Department of Social Services (DSS), or they will be denied Medicaid reimbursement.

1. Written documentation must be received with the request for reimbursement which demonstrates that ICF/MR is the least restrictive environment feasible for this resident, as demonstrated by DSS case management attempts to place the resident in less restrictive settings with no success.

2. This documentation must include the specific reasons why placement elsewhere was unsuccessful.

D. If, according to the principle of "Least Restrictive Environment", the Consultive Committee finds that inadequate attempts have been made to utilize a less restrictive environment, the person will be denied reimbursement. All requests for ICF/MR Level-II and Level-III admission authorizations will be routinely reviewed by the Consultive Committee for adherence to the "Least Restrictive Environment" principle. The Consultive Committee will scrutinize discharge plans for each individual to determine whether more appropriate community placements are utilized as available. For both preadmission and continued stay reviews, ICF/MR placement in these levels of care will be considered only as a substitute for more appropriate community placements when the more appropriate alternative is unavailable, and not as a primary resource for these individuals.

ICF/MR DAY TREATMENT SERVICES

R455-9-34 ICF/MR Day Treatment

A. Day Treatment means the training and habilitation services for residents of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) which are delivered outside of the ICF/MR in programs currently licensed as a "Day Treatment Facility" by the State of Utah, Department of Social Services and which are:

1. intended to aid the pre-vocational, self-help skill and/or self-sufficiency skill development of a qualified ICF/MR recipient;

2. sufficient to meet the active treatment requirements of Title 42 Code of Federal Regulations, Sections 435.1009 and 483.440; and

3. fully coordinated with and integrated with the active treatment program of the ICF/MR.

B. Upon the determination of the Bureau of Facility Review in order to ascertain client eligibility and compliance with program requirements, the Bureau of Facility Review may perform, but is not limited to, the following types of reviews:

1. telephone review of the residents' services with ICF/MR and/or day treatment program; or

2. on-site review at either the day treatment program or the ICF/MR setting.

C. If a recipient is receiving day treatment as defined above, the facility must have available for review documentation which supports that:

1. the resident is age 22 or older at the time of receipt of day treatment services;

2. the Interdisciplinary Team (IDT) of the ICF/MR determined that it is in the best interest of the recipient to receive training and habilitation in a licensed community day treatment program; and

3. the recipient has been determined by the Division of Rehabilitation Services, Utah State Office of Education, as not eligible for their services, i.e., not reasonably expected to be able to participate in a sheltered workshop, supported employment or in the general work force for one year.

D. To demonstrate that the day treatment service complies with the above requirements, additional documentation available for review must include:

1. A copy of the resident's established day treatment Individualized Program Plan (IPP). The IPP must:

   a. indicate integration with the inpatient treatment plan being provided by the ICF/MR;

   b. contain measurable objectives for the resident's acquisition of skills and desirable behaviors; the Individualized Program Plan may not solely address the reduction of maladaptive or undesirable behaviors;

   c. specify time frames for accomplishment of objectives;

   d. identify the day program staff who will be responsible for the implementation and review of the Individualized Program Plan;

   e. be based on the Interdisciplinary Team findings from the ICF/MR's evaluation of the residents' care and service needs;

   f. prescribe and direct the resident's participation in an integrated active treatment program of professionally developed and supervised training and therapies necessary for the individual to obtain the stated objectives;

   g. prescribe a program of training and habilitation intended to aid the intellectual, sensorimotor, emotional and prevocational development of the resident;

   h. indicate whether the resident is prepared to advance to more production-oriented level of training, sheltered, or competitive employment; and

   i. identify the facility staff who will be responsible for monitoring the day treatment program.

E. Penalties for non-compliance can include, but are not limited to:

1. Inspection of Care deficiencies as a result of either a supplemental onsite review or other utilization review/control methods; and

2. recovery of funds by the Division of Health Care Financing.

PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) REQUIREMENTS FOR MENTAL ILLNESS (MI) OR MENTAL RETARDATION/RELATED CONDITIONS (MR)

R455-9-35 Preadmission Screening and Annual Resident Review (PASARR) Requirements for Persons with Mental Retardation/Related Conditions and/or Mental Illness - Purpose

A. The Omnibus Budget Reconciliation Act of 1987 (PL 100-203) amended Title XIX of the Social Security Act and established preadmission screening and review requirements for individuals with mental illness or mental retardation/related conditions seeking admission to Medicaid-Certified nursing facilities. The purpose of the preadmission requirements are to prevent the admission of such persons to Medicaid-Certified nursing facilities when their active treatment needs would be better met in other settings.

B. The Act established screening and review requirements for persons with mental illness or mental retardation that reside in Medicaid-[illegible] nursing facilities. The Act requires the State to determine the level of services the resident requires and whether or not they require active treatment for mental illness or mental retardation. If the resident requires active treatment for mental illness or mental retardation, the Act requires they be discharged (with some exceptions) to an alternative appropriate institutional or non-institutional setting. The purpose of the requirements are to ensure, regardless of placement, that the individual receives active treatment for their mental illness or mental retardation if it is determined they require active treatment.

R455-9-36 PASARR Authority

A. This policy is intended to implement the following provisions of Section 1919 of the Social Security Act:

1. Section 1919(b)(3)(F) which prohibits a Medicaid-Certified nursing facility from admitting any new resident who has mental illness or mental retardation (or a related condition) unless the State mental health or mental retardation authority has determined prior to admission that, because of the physical and mental condition of the individual, they require the level of services provided by a nursing facility and whether the individual requires active treatment.

2. **Section 1919(e)(7) which requires the State to have, as a condition of approval of its State Medicaid plan, a preadmission screening and annual resident review program for Medicaid-Certified nursing facility applicants/residents with mental illness or mental retardation using criteria established for this purpose by the Secretary of Health and Human Services under Section 1919(f)(8) of the Act.**

R455-9-37 PASARR Definitions

A. "Active Treatment for Individuals with Mental Illness", in accordance with Section 1919(e)(7)(G)(iii) of the Social Security Act, means the implementation of an individualized plan of care developed under the supervision of a physician, provided by a physician and other qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health professionals.

B. "Active Treatment for Individuals with Mental Retardation/Related Conditions", in accordance with Section 1919 (e)(7)(G)(iii) of the Social Security Act and the 42 Code of Federal Regulations (483.440), means a continuous program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment and health services and related services that is directed towards: (1) the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

C. "Advanced Years", for purposes of this policy, means an individual who's physical and medical condition is typical of a geriatric population. In determining an individual to be of "Advanced Years", there is no unilateral chronological age which may be applied.

D. "Licensed Health Care Professional", for purposes of this policy, means a physician, physician assistant, nurse practitioner, physical, speech or occupational therapist, registered professional nurse, licensed practical nurse and licensed or certified social worker or social service worker who holds current licensure for their respective profession.

E. "Mental Illness", in accordance with Section 1919(e)(7)(G)(i) and 1919(f)(8)(A) of the Social Security Act, means an individual who has a current primary or secondary diagnosis of major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, DSM-IIIR) limited to schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis, and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

F. "Mental Retardation/Related Conditions", in accordance with the 42 Code of Federal Regulations (435.1009) and Section 1919(e)(7)(G)(ii) and 1919(f)(8)(A) of the Social Security Act, means:

1. An individual who has a level of retardation (mild, moderate, severe and profound) as described in the American Association of Mental Deficiency's Manual on Classification in Mental Retardation (1983).

   a. "Mental retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifest during the developmental period.

      (1) "Significantly subaverage intellectual functioning" means a score of two or more standard deviations below the mean on a standardized general intelligence test.

      (2) "Developmental period" means the period of time between conception and the eighteenth birthday.

2. "Related Conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

   a. It is attributable to:

      (1) cerebral palsy, epilepsy or autism; or

      (2) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment in general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

   b. It is manifest before the person reaches age 22.

   c. It is likely to continue indefinitely.

   d. It results in substantial functional limitations in three or more of the following areas of major life activity:

      (1) self care;

      (2) understanding and use of language;

      (3) learning;

      (4) mobility;

      (5) self direction;

      (6) capacity for independent living.

G. "Nursing Facility", for purposes of this policy, means an institution licensed and certified to provide long term care and includes those facilities previously or currently licensed and Medicaid-Certified as an Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF), or Swing Bed Hospital (SBH). An Intermediate Care Facility for the Mentally Retarded (ICF/MR) is not considered a "nursing facility".

H. "Resident", for the purposes of this policy, means an individual residing in and receiving medical long term nursing services in a Medicaid-Certified nursing facility.

I. "Terminally Ill", in accordance with Section 1861 (dd) (3) (A) of the Social Security Act, means an individual who has a medically prognosed life expectancy of six months or less as certified by a physician.

PREADMISSION SCREENING REQUIREMENTS FOR ALL APPLICANTS

R455-9-38 PASARR Preadmission Requirements

A. Identification (ID) Screening for Individuals with Mental Illness or Mental Retardation/Related Conditions:

1. The purpose of the Identification (ID) Screening is to determine which Medicaid-Certified nursing facility applicants/residents may have mental illness or mental retardation/related conditions and are, therefore, subject to a Preadmission Screening and Annual Resident Review (PASARR).

2. The ID Screening will be based on federal minimum criteria required under Section 1919 (b)(3)(F) of the Social Security Act and must, at a minimum, include an evaluation of the following criteria to determine whether the applicant/resident is either mentally retarded/related conditions or mentally ill:

a. Screening Criteria for Mental Illness:

(1) The individual has a diagnosis of mental illness.

(2) The individual has any recent (within the last two years) history of mental illness, or has been prescribed a major tranquilizer on a regular basis in the absence of a justifiable neurological disorder.

(3) There is any presenting evidence of mental illness (except a primary diagnosis of Alzheimer's Disease or dementia) including possible disturbances in orientation, affect or mood.

b. Screening Criteria for Mental Retardation/Related Conditions:

(1) The individual has a diagnosis of mental retardation or related condition.

(2) The individual has a history of mental retardation or related conditions.

(3) There is any presenting evidence (cognitive or behavioral functions) that may indicate the person has mental retardation or a related condition.

(4) The person has received services from or has been referred by an agency that serves persons with mental retardation/related conditions or other developmental disabilities and the person has been deemed to be

3. Findings from the Screening must be used to make one of the following determinations:

   a. Mentally ill/mentally retarded:

      Any individual for whom there is a positive response for one or more of the ID Screening Evaluation criteria for mental retardation/related conditions or mental illness.

   b. Dementia:

      Any individual who has a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) that is based on criteria in the DSM-IIIR, excluding individuals with a primary diagnosis of mental retardation/related conditions.

   c. Not mentally retarded/mentally ill:

      Any individual for whom there is a negative response for all of the ID Screening Evaluation criteria for mental illness or mental retardation/related conditions and for whom there is no other evidence of a condition of mental illness or mental retardation/related condition.

4. Applicants seeking admission to Medicaid-Certified nursing facilities must meet the following ID Screening requirements:

   a. A Medicaid-Certified nursing facility must not admit, on or after January 1, 1989, any new resident unless a licensed health care professional has completed an ID Screening and determined whether the applicant may be mentally ill or mentally retarded and therefore subject to the Preadmission Screening and Annual Resident Review (PASARR) process.

   b. The ID Screening must be completed prior to authorization for admission to and Medicaid reimbursement for nursing facility services. If the ID screening indicates the applicant is subject to the PASARR process, Medicaid reimbursement will not be authorized until the PASARR is completed and a determination made that the applicant is appropriate for placement in a nursing facility.

   c. The ID Screening must be completed by a licensed health care professional. The individual completing the Screening must record the results on a report form supplied for this purpose by the Utah State Department of Health, Division of Health Care Financing. The report must include the date of the Screening and signature of the person(s) completing the screening.

d. If the Screening results in the determination of "Mentally Ill/Mentally Retarded" under R455-9-38, A, 3, a, the individual may not be admitted to reside in a Medicaid-Certified nursing facility without being determined appropriate for nursing facility placement through the PASARR process. The applicant must be referred and a copy of the ID Screening report submitted to the Division of Mental Health (for mental illness) or Division of Services to the Handicapped (for mental retardation/related conditions) in the Utah State Department of Social Services for completion of the PASARR process. If there is a positive response on indicators for both mental illness and mental retardation/related condition, the individual must be referred to both Divisions.

e. If the Screening results in the determination of "Dementia" under R455-9-38, A, 3, b, or "Not Mentally Ill/Mentally Retarded" under R455-9-38, A, 3, c, the applicant is not subject to the PASARR determination process for admission to a Medicaid-Certified nursing facility.

f. A copy of the ID Screening report must be retained in the resident's nursing facility record if they are admitted to the nursing facility.

g. Regardless of the ID Screening determination, the nursing facility is required to submit a copy of the ID Screening report to the Utah Department of Health, Division of Health Care Financing Bureau of Facility Review, for any applicant admitted to their facility.

5. Current residents of Medicaid-Certified nursing facilities must meet the following ID Screening requirements:

a. An ID Screening must be completed by June 30, 1989, for all residents of Medicaid-Certified nursing facilities who were admitted prior to January 1, 1989, and have continued to reside in the facility since that date. The ID Screening must be completed prior to June 30, 1989, for continued authorization for Medicaid reimbursement for nursing facility services.

b. The ID Screening must be completed by a licensed health care professional. The individual completing the Screening must record the results on a report form supplied for this purpose by the Utah State Department of Health, Division of Health Care Financing. The report must include the date of the Screening and signature of the person(s) completing the screening.

c. If the Screening results in the determination of "Mentally Ill/Mentally Retarded" under R455-9-38, A, 3, a, the individual may not continue to reside in a Medicaid-Certified nursing facility without being referred for continuation in the PASARR process. The resident must be referred and a copy of the ID Screening report submitted to the Division of Mental Health (for mental illness) or Division of Services to the Handicapped (for mental retardation/related conditions) in the Utah State Department of Social Services for completion of the PASARR process. If there is a positive response on indicators for both mental illness and mental retardation/related condition, the individual must be referred to both Divisions.

d. If the Screening results in a determination of "Dementia" under R455-9-38, A, 3, b, or "Not Mentally Ill/Mentally Retarded" under R455-9-38, A, 3, c, the resident is not subject to the PASARR determination process for continued residence in a Medicaid-Certified nursing facility.

e. A copy of the ID Screening report must be retained in the resident's nursing facility record.

f. Regardless of the ID Screening determination, the nursing facility is required to submit a copy of the ID Screening report to the Utah Department of Health, Division of Health Care Financing Bureau of Facility Review for all residents.

PREADMISSION EVALUATION REQUIREMENTS FOR PERSONS WITH MI AND/OR MR

B. Preadmission Screening and Annual Resident Review (PASARR) for Medicaid-Certified Nursing Facility Applicants/Residents with Mental Illness or Mental Retardation/Related Conditions

1. The purpose of the PASARR evaluation process is to determine whether individuals with mental illness or mental retardation/related conditions who are applicants to or residents of Medicaid-Certified nursing facilities require the level of services provided by a nursing facility and whether or not the individual requires active treatment for mental illness and/or mental retardation/related conditions.

2. The PASARR evaluation will be based on Federal minimum criteria required under Section 1919(f)(8) of the Social Security Act. The Utah Department of Social Services, Division of Mental Health (DMH) and/or Division of Services to the Handicapped (DSH) are required to complete the PASARR that includes, at a minimum, an evaluation of the following criteria:

   a. the level of nursing service needs for individuals with a diagnosis of mental illness and/or mental retardation/related conditions;

   b. active treatment needs for individuals with mental retardation/related conditions;

   c. active treatment needs for individuals with mental illness;

   d. active treatment needs for individuals with mental illness and mental retardation/related conditions;

   e. whether or not the individual has resided in the nursing facility for 30 months or longer (from the date of the PASARR determination).

3. DMH and DSH must use the findings from the PASARR evaluation to make one of the following determinations:

   a. Nursing facility services not needed:

      Any individual with mental illness or mental retardation/related conditions not in need of the level of services provided by a nursing facility, whether or not active treatment services are required.

b. Need active treatment services:

Any individual with mental illness or mental retardation/related conditions in need of active treatment services unless criteria (d),(e),(f), (g) or (h) below are applicable.

c. Need nursing facility services, active treatment services not needed:

Any individual with mental illness or mental retardation/related conditions in need of the level of services provided by a nursing facility but not in need of active treatment services.

d. Need active treatment, advanced years, chooses nursing facility services:

Any individual with mental illness or mental retardation/related conditions in need of both the level of services provided by a nursing facility as well as active treatment, who is of advanced years, who is competent to make an independent decision and who is not a danger to self or others, (i.e. assaultive and/or self abusive) and chooses not to participate in active treatment services.

e. Convalescent care:

Any individual with mental illness or mental retardation/related conditions, who is not a danger to self and/or others, who requires a medically prescribed period of recovery in a nursing facility (not to exceed 120 days), and who is being released from an acute care setting.

f. Terminal illness:

(1) Any individual with mental illness or mental retardation/related conditions, who is not a danger to self and/or others, who is certified by a physician to be "terminally ill", and who requires continuous nursing care and/or medical supervision/treatment due to a physical condition.

(2) For purposes of applying this criterion, the nature and extent of the individual's need for nursing services and medical supervision and treatment shall be considered the determining factor, while the existence of a chronic mental or physical disability shall be treated as an incidental consideration.

g. Severe illness:

(1) Any individual with mental illness or mental retardation/related conditions who is comatose, ventilator dependent, functions at the brain stem level or has a diagnosis of: chronic obstructive pulmonary disease, severe Parkinson's disease, Huntington's disease, Amyolateraltropic Sclerosis, or congestive heart failure or any other diagnosis so designated by HCFA.

(2) For purposes of applying this criteria, the severity of illness would prohibit the individual from participating in active treatment services. There must be documented evidence of their conditions.

h. Need active treatment, over 30 months continuous residence in a nursing facility, chooses to remain in the nursing facility:

(1) Any individual with mental illness or mental retardation/related conditions in need of active treatment services, who is not in need of nursing facility services, who has continuously resided in a Medicaid-Certified nursing facility for 30 months or more from the date of the PASARR determination, and chooses to remain in the nursing facility.

(2) For purposes of applying this criteria, intervening hospitalizations will not be considered disruptive of the 30 month continuous nursing facility residence determination.

4. Applicants with mental illness and/or mental retardation/related conditions seeking admission to Medicaid-Certified nursing facilities must meet the following PASARR requirements:

a. On or after January 1, 1989, a Medicaid-Certified nursing facility must not admit any individual who is mentally ill, as identified by the ID Screening, unless the Division of Mental Health (DMH) has made a PASARR determination (based on an independent physical and mental evaluation performed by a person or entity other than DMH) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by the nursing facility, and if the individual requires such level of services, whether the individual requires active treatment for mental illness. Medicaid reimbursement for nursing facility services will not be authorized prior to completion of the PASARR evaluation and determination by DMH that the applicant meets PASARR criteria for placement in a Medicaid-Certified nursing facility.

b. On or after January 1, 1989, a Medicaid-Certified nursing facility must not admit an individual who is mentally retarded/related condition, as identified by the ID Screening, unless the Division of Services to the Handicapped (DSH) has made a PASARR determination prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation/related conditions. Medicaid reimbursement for nursing facility services will not be authorized prior to completion of the PASARR evaluation and determination by DSH that the applicant meets PASARR criteria for placement in a Medicaid-Certified nursing facility.

c. Upon completion of the ID Screening and referral to the Division of Mental Health (DMH) and/or Division of Services to the Handicapped (DSH), DMH and/or DSH will complete the PASARR evaluation and make a determination based on Federal minimum criteria developed by the United States Department of Health and Human Services as required by Section 1919(f)(8) of the Social Security Act.

d. Based on the PASARR determination criteria, determination decisions for admission to a Medicaid-Certified nursing facility and authorization for Medicaid reimbursement are as follows:

(1) If the determination is "Nursing Facility Services Not Needed" R455-9-38, B, 3, a, the applicant shall be considered inappropriate for placement in a Medicaid-Certified nursing facility and not entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility.

(2) If the determination is "Need Active Treatment Services" under 455-9-38, B, 3, b, the applicant shall be considered inappropriate for placement in a Medicaid-Certified nursing facility and not entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility.

(3) If the determination is "Need Nursing Facility Services, Active Treatment Services Not Needed" under 455-9-38, B, 3, c, the applicant shall be considered appropriate for placement in a Medicaid-Certified nursing facility and entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other preadmission criteria are met as required by R455-9-6 and R455-9-7.

(4) If the determination is "Need Active Treatment, Advanced Years, Chooses Nursing Facility Services" under 455-9-38, B, 3, d, the applicant shall be considered appropriate for placement in a Medicaid-Certified nursing facility and entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other preadmission criteria are met as required by R455-9-6 and R455-9-7.

(5) If the determination is "Convalescent Care" under 455-9-38, B, 3, e, the applicant may be admitted to a Medicaid-Certified nursing facility for a period not to exceed 120 days without being subjected to the PASARR evaluation for determination of active treatment needs. The applicant will be entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility for a period not to exceed 120 days if all other preadmission criteria are met as required by R455-9-6 and R455-9-7.

i. Continued placement in the facility and Medicaid reimbursement authorization beyond the 120 days will require a PASARR evaluation of active treatment needs and a finding that PASARR determination criteria R455-9-38 B, 3, c, d, f, g, or h as specified in this policy, are applicable.

(6) If the determination is "Terminal Illness" under R455-9-38, B, 3, f, or "Severe Illness" under R455-9-38, B, 3, g, the applicant may be admitted to a Medicaid-Certified nursing facility without being subjected to the PASARR evaluation for determination of active treatment needs. The applicant will be entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other preadmission criteria are met as required by R455-9-6 and R455-9-7.

e. If at any time during the PASARR process DMH/DSH find that the individual is not mentally ill and/or mentally retarded/related conditions, or has a primary diagnosis of dementia (excluding mental retardation/related conditions), the PASARR process may be stopped. DMH/DSH will prepare a report documenting this determination and provide a copy to the nursing facility which must be retained in the resident's record if they are admitted to the facility. A copy of the report must be submitted to the Utah Department of Health, Division of Health Care Financing, Bureau of Facility Review prior to authorization for Medicaid reimbursement for care in a Medicaid-Certified nursing facility.

f. Upon completion of the PASARR evaluation and determination, DMH/DSH will prepare a report containing the results of the evaluation and determination. They will provide a copy of the PASARR report to the nursing facility which must be retained in the resident's record if they are admitted to the facility. Prior to authorization for Medicaid reimbursement for care in a Medicaid-Certified nursing facility, a copy of the report must be submitted to the Utah Department of Health, Division of Health Care Financing, Bureau of Facility Review.

g. Any individuals adversely affected by PASARR determinations under R455-9-38, B, 3, and B, 4, d shall have the right to appeal to the Division of Health Care Financing in accordance with the Utah Administrative Procedures Act (UAPA), Utah Code Ann. 63-46b-1 et seq.

5. Current residents of Medicaid-Certified nursing facilities with mental illness and/or mental retardation/related conditions must meet the following PASARR requirements:

a. By March 31, 1990, any resident of Medicaid-Certified nursing facility who is mentally ill, as indicated by the ID Screening, must have a PASARR determination by DMH (based on an independent physical and mental evaluation performed by a person or entity other than DMH), that, because of the physical and mental condition of the individual, the individual requires the level of services provided by the nursing facility, and if the individual requires such level of services, whether the individual requires active treatment for mental illness. Medicaid reimbursement for nursing facility services will not be authorized after March 31, 1990, unless the PASARR evaluation has been completed and DMH has determined the resident is appropriate for continued placement in a Medicaid-Certified nursing facility.

b. By March 31, 1990, any resident of Medicaid-Certified nursing facility with mental retardation/related condition, as indicated by the ID Screening, must have a PASARR determination by DSH, that, because of the physical and mental condition of the individual, the individual requires the level of services provided by the nursing facility, and if the individual requires such level of services, whether the individual requires active treatment for mental retardation/related conditions. Medicaid reimbursement for nursing facility services will not be authorized after March 31, 1990, unless the PASARR evaluation has been completed and DSH has determined the resident is appropriate for continued placement in a Medicaid-Certified nursing facility.

c. Upon completion of the ID Screening and referral to the Division of Mental Health (DMH) and/or Division of Services to the Handicapped (DSH), DMH and/or DSH will complete the PASARR evaluation and make a determination based on Federal minimum criteria developed by the United States Department of Health and Human Services as required by Section 1919(f)(8) of the Social Security Act.

d. Based on the PASARR determination criteria, determination decisions for continued placement in a Medicaid-Certified nursing facility and authorization for Medicaid reimbursement are as follows:

(1) If the determination is "Nursing Facility Services Not Needed" under R455-9-38, B, 3, a, the resident shall be considered inappropriate for continued placement in a Medicaid-Certified nursing facility and not entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility. DMH and/or DSH, in conjunction with the nursing facility, shall arrange for the safe and orderly discharge of the resident from the facility and prepare and orient the resident for such discharge.

(2) If the determination is "Need Active Treatment Services" under R455-9-38, B, 3, b, the resident shall be considered inappropriate for continued placement in a Medicaid-Certified nursing facility and not entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility. DMH and/or DSH, in consultation with the resident's family, or legal representative and care-givers shall arrange for the safe and orderly discharge of the resident from the facility, prepare and orient the resident for such discharge and provide for (or arrange for the provision of) active treatment services for the mental illness or mental retardation/related conditions.

(3) If the determination is "Need Nursing Facility Services, Active Treatment Services Not Needed" under R455-9-38, B, 3, c, the resident shall be considered appropriate for continued placement in a Medicaid-Certified nursing facility and entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other continued stay criteria are met as required by R455-9-12.

(4) If the determination is "Need Active Treatment, Advanced Years, Chooses Nursing Facility Services" under R455-9-38, B, 3, d, the resident shall be considered appropriate for continued placement in a Medicaid-Certified nursing facility and entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other continued stay criteria are met as required by R455-9-12.

(5) If the determination is "Convalescent Care" under R455-9-38, B, 3, e, the resident may continue to reside in a Medicaid-Certified nursing facility for a period not to exceed 120 days without being subjected to the PASARR evaluation for determination of active treatment needs. The resident will be entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility for a period not to exceed 120 days if all other continued stay criteria are met as required by R455-9-12.

i. Continued placement in the facility and Medicaid authorization beyond the 120 days will require a PASARR evaluation of active treatment needs and a finding that PASARR determination criteria R455-9-38, B, 3, c, d, f, g, or h as specified in this policy are applicable.

(6) If the determination is "Terminal Illness" under R455-9-38, B, 3, f, or "Severe Illness" under R455-9-38, B, 3, g, the resident may continue to reside in a Medicaid-Certified nursing facility without being subjected to the PASARR evaluation for determination of active treatment needs. The resident will be entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other continued stay criteria are met as required by R455-9-12.

(7) If the determination is "Need Active Treatment, Over 30 Months Continuous Residence in a Nursing Facility, Chooses to Remain in the Nursing Facility" under R455-9-38, B, 3, h, the resident shall be considered appropriate for continued placement in a Medicaid-Certified nursing facility if the resident is provided with active treatment services for the mental illness and/or mental retardation. The resident will be considered entitled to Medicaid reimbursement for services in a Medicaid-Certified nursing facility if all other continued stay criteria are met as required by R455-9-12 and the resident is receiving active treatment for the mental illness and/or mental retardation.

i. Prior to the resident making a choice about remaining in the nursing facility, DSH and/or DMH will inform the resident of the institutional and non-institutional alternatives covered under the State plan for the resident;

ii. offer the resident the choice of remaining in the facility or receiving covered services in an alternative appropriate institutional or non-institutional setting; and

iii. clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effects on readmission to the facility).

e. If at any time during the PASARR process, DMH/DSH find that the individual is not mentally ill or mentally retarded/related conditions, or has a primary diagnosis of dementia (unless they are mentally retarded/related conditions), the PASARR process may be stopped. DMH/DSH will prepare a report documenting this determination and provide a copy to the nursing facility which must be retained in the resident's record. DMH/DSH will also submit a copy of the report to the Utah Department of Health, Division of Health Care Financing, Bureau of Facility Review.

f. Upon completion of the PASARR evaluation and determination, DMH/DSH will prepare a report containing the results of the evaluation and determination. They will provide a copy of the PASARR report to the nursing facility which must be retained in the resident's record. DMH/DSH will also submit a copy of the report to the Utah Department of Health, Division of Health Care Financing, Bureau of Facility Review.

g. Any individuals adversely affected by PASARR determinations under R455-9-38, B, 3, and B, 5, d shall have the right to appeal to the Division of Health Care Financing in accordance with the Utah Administrative Procedures Act (UAPA), Utah Code Ann. 63-46b-1 et seq.

R455-9-39 PASARR Hospital Readmission Requirements

A. A Medicaid-Certified nursing facility resident who has been hospitalized for more than three consecutive days (not counting day of admission to the hospital), who has not previously been subjected to the ID Screening and/or PASARR process, and is seeking readmission to a Medicaid-Certified nursing facility, will be subject to the ID Screening and, if indicated by the ID Screening, subject to the PASARR process prior to readmission.

B. A Medicaid-Certified nursing facility resident who has been hospitalized for more than three consecutive days (not counting day of admission to the hospital), who has previously been subjected to the ID Screening and/or PASARR process, and is seeking readmission to a Medicaid-Certified nursing facility will not be subject to the ID Screening/PASARR process unless there is an indication that their mental or physical care needs have changed substantially from the time of their previous ID Screening/PASARR determination. The nursing facility will be responsible to make this determination, ensure a new ID Screening is completed and the individual, as indicated, is referred to DMH/DSH for the PASARR evaluation.

R455-9-40 PASARR Telephone Contact Authorization Requirements

A. Telephone contact authorization for immediate placement in a nursing facility, as specified in R455-9-6, R455-9-7 and R455-9-9, will not be granted unless the ID Screening has been completed.

1. If the ID Screening results in a determination of "Dementia" (excluding mental retardat on/related conditions) or "Not Mentally Ill/Mentally Retarded", authorization will be granted assuming all other conditions are met as required by R455-9-6, R455-9-7 and R455-9-9.

2. If the ID Screening results in a determination of "Mentally Ill/Mentally Retarded", authorization for immediate placement will not be granted unless the PASARR has been completed and the Division of Mental Health (DMH) and/or the Division of Services to the Handicapped (DSH) have determined placement in a Medicaid certified nursing facility is appropriate, or DSH/DMH has determined the PASARR is not required and all other conditions, as required by R455-9-6, R455-9-7, and R455-9-9 are met.

R455-9-41 PASARR Requirements for Annual Review

A. Any individual who required a PASARR evaluation and determination by DMH/DSH for continued placement in a Medicaid-Certified nursing facility is subject to a Annual Review (PASARR) as long as they continue to reside in a Medicaid-Certified nursing facility.

1. All requirements as specified in R455-9-38, B, 5 of this policy apply to the Annual Review.

2. DMH/DSH will establish the annual review date at the time the preadmission or initial PASARR is completed. For administrative purposes, the the annual review date will be defined as the calendar month in which it is due.